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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3895  
CERTIFICATE OF DEATH

Reg. Dist. No. 03891

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>247 Baltimore Ave.</b>		d. STREET ADDRESS <b>/ 247 Baltimore Ave.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HELEN</b> First <b>M.</b> Middle <b>AHRENS</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1897</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Maeby</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Knealy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Henry F. Ahrens 2865 Plainfield Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>28 Hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 18, 1961</b> to <b>April 19, 1961</b> that I last saw the deceased alive on <b>April 19, 1961</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. <b>6800 Monmouth Road</b> <b>Dundalk - Md</b> DATE SIGNED <b>4/20/61</b>	
PHYSICIAN'S NAME (Type) <b>M.B. Davis, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 22, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		22d. LOCATION (City, town, or county) (State) <b>Overlea, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 21 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]*

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 10 File 6286 5/8/61 JWK											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28, Maryland</b> c. LENGTH OF STAY IN 1b <b>24 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>116 S. Culver Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Amer</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1961</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/23/87</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman, Ret'd.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Belle City</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>John H. Amer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Caldwell</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>218-26-3453</b>		17. INFORMANT <b>RECORDS: Spring Grove State Hospital</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 14, 1961</b> to <b>April 28, 1961</b> , that (I) (we) lost saw the deceased alive on <b>April 28, 1961</b> and that death occurred at <b>9a</b> M., from the causes and on the date stated above.											
22a. SIGNATURE <b>Loretta Hsu</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>April 28, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Loretta Hsu M.D.</b>				22d. ADDRESS <b>Spring Grove State Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>May 2/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town, or county) (State) <b>Belle, Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke</b>				ADDRESS <b>4110 Edmondson Ave</b>				25a. REC'D BY REGISTRAR <b>MAY 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3897

## CERTIFICATE OF DEATH

Reg. Dist. No. 03892

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1918 Stanhope Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>E.</b> Last <b>AMEY SR.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1896</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George E. Amey</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Kaiser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Lucille Amey</b>		Address <b>1918 Stanhope Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the right lungs</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3-2-61</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>3-2</b> , 19 <b>61</b> , to <b>4-17</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>4-16</b> , 19 <b>61</b> , and that death occurred at <b>1:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7001 Mornington Rd</b> DATE SIGNED <b>4-19-61</b> ACTUAL SIGNATURE <b>Eugene F Nevy</b> M.D. <b>Dundalk, Md.</b> PHYSICIAN'S NAME (Type) <b>Eugene F Nevy</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-21-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc.,</b>		ADDRESS <b>1901 Eastern Avenue</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 19 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OUTLINE  
LWM BOND

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. PLACE OF DEATH [Illegible]		10. TIME OF DEATH [Illegible]	
11. SIGNATURE OF PHYSICIAN [Illegible]		12. SIGNATURE OF REGISTRAR [Illegible]	
13. DATE OF DEATH [Illegible]		14. PLACE OF INTERMENT [Illegible]	
15. SIGNATURE OF WITNESS [Illegible]		16. SIGNATURE OF WITNESS [Illegible]	
17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF WITNESS [Illegible]	
19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]	
21. SIGNATURE OF WITNESS [Illegible]		22. SIGNATURE OF WITNESS [Illegible]	
23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	
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27. SIGNATURE OF WITNESS [Illegible]		28. SIGNATURE OF WITNESS [Illegible]	
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31. SIGNATURE OF WITNESS [Illegible]		32. SIGNATURE OF WITNESS [Illegible]	
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59. SIGNATURE OF WITNESS [Illegible]		60. SIGNATURE OF WITNESS [Illegible]	
61. SIGNATURE OF WITNESS [Illegible]		62. SIGNATURE OF WITNESS [Illegible]	
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73. SIGNATURE OF WITNESS [Illegible]		74. SIGNATURE OF WITNESS [Illegible]	
75. SIGNATURE OF WITNESS [Illegible]		76. SIGNATURE OF WITNESS [Illegible]	
77. SIGNATURE OF WITNESS [Illegible]		78. SIGNATURE OF WITNESS [Illegible]	
79. SIGNATURE OF WITNESS [Illegible]		80. SIGNATURE OF WITNESS [Illegible]	
81. SIGNATURE OF WITNESS [Illegible]		82. SIGNATURE OF WITNESS [Illegible]	
83. SIGNATURE OF WITNESS [Illegible]		84. SIGNATURE OF WITNESS [Illegible]	
85. SIGNATURE OF WITNESS [Illegible]		86. SIGNATURE OF WITNESS [Illegible]	
87. SIGNATURE OF WITNESS [Illegible]		88. SIGNATURE OF WITNESS [Illegible]	
89. SIGNATURE OF WITNESS [Illegible]		90. SIGNATURE OF WITNESS [Illegible]	
91. SIGNATURE OF WITNESS [Illegible]		92. SIGNATURE OF WITNESS [Illegible]	
93. SIGNATURE OF WITNESS [Illegible]		94. SIGNATURE OF WITNESS [Illegible]	
95. SIGNATURE OF WITNESS [Illegible]		96. SIGNATURE OF WITNESS [Illegible]	
97. SIGNATURE OF WITNESS [Illegible]		98. SIGNATURE OF WITNESS [Illegible]	
99. SIGNATURE OF WITNESS [Illegible]		100. SIGNATURE OF WITNESS [Illegible]	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3893

03893

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>HENRY - W - ARMACOST</u>				4. DATE OF DEATH <u>April 13</u> 19 <u>61</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 8 - 1874</u>	
9. AGE (in years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>			
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John H Annacost</u>				14. MOTHER'S MAIDEN NAME <u>Martha Bush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-07-5186</u>			
17. INFORMANT <u>Robert Annacost</u>				Address <u>Upperco MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> 19 <u>61</u> to <u>April 13</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Apr 13</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush - MD</u>				22d. ADDRESS <u>Hampstead Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-15-1961</u>		<u>St Pauls</u>		<u>Balto Co MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton</u>				ADDRESS <u>Hampstead MD</u>		25a. REC'D BY REGISTRAR	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
				DATE <u>APR 17 '61</u>			

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Decedent's Name: [Illegible]  
Age: [Illegible]  
Sex: [Illegible]  
Race: [Illegible]  
Date of Birth: [Illegible]

Place of Birth: [Illegible]  
Usual Residence: [Illegible]

Occupation: [Illegible]  
Cause of Death: [Illegible]

Immediate Cause: [Illegible]  
Underlying Cause: [Illegible]

Contributing Cause: [Illegible]  
Manner of Death: [Illegible]

Signature of Physician: [Illegible]  
Signature of Registrar: [Illegible]

Date: [Illegible]  
Place: [Illegible]

Signature of Medical Examiner: [Illegible]  
Signature of Coroner: [Illegible]

Signature of [Illegible]: [Illegible]  
Signature of [Illegible]: [Illegible]

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
3899  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03894

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Towson Convul. Home</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>305 Alabama Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEAH</b> Middle <b>DEMOLL</b> Last <b>BAILY</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 5, 1907</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>54</b> Days <b>54</b>	IF UNDER 24 HRS. Hours <b>54</b> Min. <b>54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Otto J. DeMoll</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Hill</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Frederick R. Baily-305 Alabama Rd. Towson</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>BRONCHOPNEUMONIA</b> 962X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>INANITION</b> DUE TO (c) <b>OLD BRAIN INJURY (LACERATION)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>2 MOS.</b> <b>8 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>FRACURED HIP (RIGHT)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>PATIENT FELL AT HOME</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>OCT.</b> 19 <b>59</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>TOWSON</b> (County) <b>BALTIMORE</b> (State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>10/2</b> to <b>4/21</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/20</b> , 19 <b>61</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Donald L. Somerville</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD L. SOMERVILLE</b>		22b. DATE SIGNED <b>4/22/61</b>	
22d. ADDRESS <b>25 W. PA. AVE, TOWSON 4, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 24/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Gardens</b>		23d. LOCATION (City, town or county) <b>Timonium, Maryland</b> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc. York Rd. Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 24 '61</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

03884

03884



Salisbury

Salisbury

Salisbury

Town

Town

305 Alabama St.

Town Council, Town

April 21, 1961

BAIRN

BAIRN

BAIRN

Feb. 2, 1967

Kenzie

USA

Washington, D.C.

Honorable

Samuel Hill

John J. DeLoe



Woods Frederick H. Bairn-305 Alabama St. - Town

Woods

No

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John and Mary

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John and Mary

April 21/61 Dulany Valley - Salisbury, Maryland  
Wm Cook-Town, Inc. York Rd. Town, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3300

03895

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b lytllmth7dys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 21 North Carey Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry		Middle Bankard		Last Bankard		4. DATE OF DEATH Month April		Day 1	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 14, 1888		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) construction worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Eugene Bankard		14. MOTHER'S MAIDEN NAME Mamie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-07-2946-A		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO Arteriosclerotic cardiovascular disease (b) Arteriosclerosis, generalized and severe (c) Arteriosclerosis, generalized and severe		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)		20i. (City or town) (County) (State)		20j. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 22, 1961 to April 1, 1961, that (I) (we) last saw the deceased alive on April 1, 1961 and that death occurred at 1:30 P. M. from the causes and on the date stated above.		22a. SIGNATURE Stella Wachler		22b. DATE SIGNED 4-4-61		22c. PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/61		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.		23d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE The MacNabb Funeral Home, Catonsville, Md.		25a. REC'D BY REGISTRAR DATE APR 5 '61		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

100

10380

Blank form with horizontal lines for text entry.

Billie K. ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 22b, Film G-286 5/2/61.cac.											
03896											
1. PLACE OF DEATH Items 20 & 21, Film G-287				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)							
a. COUNTY				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
BALTIMORE				Towson				BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
418 Overbrook Rd.				418 Overbrook Rd. -12							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. AGE (In years last birthday)			
JUNE P. BOGUE				April 26, 19 61				42 yrs.			
5. SEX				6. COLOR OR RACE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
Female				White				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Clerical				Office				Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
H. Norbert Paul				Charlotte Trumbo				USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Address			
no				no				H. Norbert Paul Jr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overdose of barbiturates.											
970.2 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
				Took overdose of sleeping pills.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4/26/61. Found: p.m. 5:15 PM 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
								20f. (City or town) Baltimore, Md. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
William V. Lovitt, Jr., M. D.				Address (Street, city, town, or county)				April 27, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY			
Burial				4-29-61				Lorraine Park			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
H.W. Jenkins & Sons Co. 4905 York Rd.				APR 28 '61				Wm. S. Thomas			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3902

Items 2 & 13 Film G285 5/1/61 iwk

03897

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ARMACOST N.H.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>MD.</b> <span style="float: right;">b. COUNTY <b>BALTO.</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> d. STREET ADDRESS <b>529 ANNESLIE RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ADA R. BORLAND</b>			<b>4. DATE OF DEATH</b> <b>4 22 1961</b>		<b>5. SEX</b> <b>F</b>		
<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>APRIL 7, 1879</b>			
<b>9. AGE</b> (In years last birthday) <b>82 Yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PENNA.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>CHARLES W. BORLAND</b> <span style="float: right;">Coleman</span>		<b>14. MOTHER'S MAIDEN NAME</b> <b>MARTHA JANE GOBRECHT</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-</b>		<b>17. INFORMANT</b> <b>MRS. MAUD C. ANDERSON</b> <span style="float: right;">Address ABOVE</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> (b) <b>Generalized arteriosclerosis</b> (c) <b>332X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1959 to Apr 22, 1961, that (I) (we) last saw the deceased alive on Apr 22, 1961, and that death occurred at 8:30 AM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Frederick J. Vollmer</b> <span style="float: right;">M.D.</span>				<b>22b. DATE SIGNED</b> <b>4-24-61</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>FREDERICK J. VOLLMER</b>				<b>22d. ADDRESS</b> <b>6100 YORK RD BALTIMORE-12, MD</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>4-26-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>NEW OXFORD</b>			
<b>23d. LOCATION</b> (City, town or county) <b>NEW OXFORD</b>		<b>(State)</b> <b>PA</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H.W. JENKINS &amp; SONS Co. 4905 YORK RD.</b>			
<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 24 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18****3903****CERTIFICATE OF DEATH**

Reg. Dist. No.

**03898**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr4mth3dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Boswell</b> Last <b>Boswell</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1888</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Joh--unknown-- George W. Jackson</b>	
14. MOTHER'S MAIDEN NAME <b>unknown----Hall</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized, severe.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 11, 1961</b> , to <b>April 18, 1961</b> , that I last saw the deceased alive on <b>April 18, 1961</b> , and that death occurred at <b>9:10<sup>a</sup></b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED ACTUAL SIGNATURE <b>Stella Wachslor</b> M.D. PHYSICIAN'S NAME (Type) <b>Stella Wachslor M.D.</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-21--1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) (State) <b>Howard County Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Max R. H. Thun</b>		24a. REC'D BY REGISTRAR DATE <b>APR 24 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. H. H.</b>			

08208

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

the death certificate has

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 3, 8, taken from birth certificate on file, 4/11/72 kam

03899

**1. PLACE OF DEATH**

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Timonium

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2109 Pine Valley Drive

**2. USUAL RESIDENCE** (Where deceased lived, if Institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Baltimore

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Timonium

d. STREET ADDRESS

2109 Pine Valley Drive

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

**3. NAME OF DECEASED**  
(Type or print)

James

HOWARD

Howard

Boyd

**4. DATE OF DEATH**

April

15

1961

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-30-1914

9. AGE (in years last birthday)

47 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supt.

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry A. Boyd

14. MOTHER'S MAIDEN NAME

Margaret Hayes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and date of service)

no

16. SOCIAL SECURITY NO.

217-03-5623

17. INFORMANT

Mrs. Margaret E. Boyd

Address

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

Coronary Occlusion  
Coronary Insufficiency

INTERVAL BETWEEN ONSET AND DEATH

Sudden  
typ

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour e.m.  
p.m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While Not While  
at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Oct 1961 to Oct 1961, that (I) (we) last saw the deceased alive on April 13, 1961, and that death occurred at 7:45 A.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

4-18-61

23c. NAME OF CEMETERY OR CREMATORY

Moreland Memorial

23d. LOCATION (City, town or county)

Balto. Co.

(State)

Md.

FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W. Jenkins & Sons Co. 4905 York Rd.

25a. REC'D BY REGISTRAR

DATE APR 18 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Hines

MEDICAL CERTIFICATION

1288

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3905 CERTIFICATE OF DEATH 03900											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>—</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>						c. LENGTH OF STAY IN 1b <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Towson Convalescent Home</b> <b>301 West Chesapeake Avenue</b>						d. STREET ADDRESS <b>825 West 35th Street</b>					
3. NAME OF DECEASED (Type or print) <b>Mattie Breidinger</b>						4. DATE OF DEATH <b>April 12, 1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 25, 1876</b>		9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days <b>12 19 61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>John Foxwell</b>						14. MOTHER'S MAIDEN NAME <b>Molly Lusby</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>						17. INFORMANT <b>Mrs. Marie Jones</b> Address <b>825 West 35th Street</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Parkinson's Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>2 years</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 10, 1961</b> to <b>April 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 10, 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Philip D. Elynn</b>						22b. DATE SIGNED <b>4/16/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Philip D. Elynn, M.D.</b>						22d. ADDRESS <b>11 E. Chase St.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>April 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b> <b>Norace A. Burgee</b>						ADDRESS <b>3631 Falls Road</b> <b>Baltimore</b>		25a. REC'D BY REGISTRAR DATE <b>APR 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3906

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>11 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>125 North Colvin</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>S</b> Last <b>BROWN</b>			4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 61</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1892</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter &amp; Plasterer (retired) Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Georgia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph S. Brown</b>			14. MOTHER'S MAIDEN NAME <b>Savannah Searles</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-1 217-05-8312</b>		17. INFORMANT <b>Clin Rec VAH Balto Md - Ft Howard Division</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN TUMOR RIGHT PARIETAL REGION</b> DUE TO <b>PULMONARY EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) (County) (State) <b>Baltimore Maryland</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>M B Davis</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS</b> , M.D.			DATE SIGNED <b>4-15-61</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-19-61</b>		22c. NAME OF CEMETERY OR-CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 18 '61</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips Baltimore 17, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>			

5088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

3907 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03902

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>37 yrs 6 mos</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Meta</b> Middle <b>Busig</b> Last <b>Busig</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1883</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Germany</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
13. FATHER'S NAME <b>Frederick Nolcke</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gunneman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>218 31-1383</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mr. August Busig 2756 Fenwick</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>157X</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 17</b> , 19 <b>61</b> , to <b>April 25</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>April 25, 1961</b> , and that death occurred at <b>A. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>1:05</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTO. MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>		25c. DATE <b>MAY 1 '61</b>	

03208

CERTIFICATE OF DEATH

3001

14

CERTIFICATE

2

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3908

Item 9 Film 6287 5/22/61 mb

05184

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Nd.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>707 Careysbrook Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roger</b> Middle <b>Ernest</b> Last <b>Butts</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1902</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>58</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>George L. Reed</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur U. Butts</b>		14. MOTHER'S MAIDEN NAME <b>Reisterstown, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>212-10-7529</b>	
17. INFORMANT <b>Mr. Roger P. Butts, Deer Park Rd.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.V. Disease</b> DUE TO (c) <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1948</b> to <b>April 30, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 30, 1961</b> , and that death occurred at <b>5 P.</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E. Wheeler</b>		22b. DATE SIGNED <b>May 17 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOS. E. WHEELER</b>		22d. ADDRESS <b>Randallstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 3, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. King</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
3909 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03903									
1. PLACE OF DEATH a. COUNTY: <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4807 Westland Blvd.</u>					d. STREET ADDRESS <u>4807 Westland Blvd</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Frances Campbell</u>					4. DATE OF DEATH Month Day Year <u>April 14, 1961</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 25, 1880</u>		9. AGE (In years last birthday) <u>81 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House duties</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Winter</u>					14. MOTHER'S MAIDEN NAME <u>Mary Sharpley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>none</u>				
17. INFORMANT <u>Mrs Doris White</u>					Address <u>107 Westland Blvd</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis. Cardio vascular heart disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Geo S M Kieffer</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>1010 Leeds Ave</u> DATE SIGNED <u>April 14, 1961</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>3/18/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Catheral Cemetery Baltimore Maryland</u>			22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard 4107 Wilkens Ave.</u>					24a. REC'D BY REGISTRAR DATE <u>APR 19 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

03003

STATE  
OF  
MICHIGAN

OFFICE OF THE  
MEDICAL EXAMINER  
STATE OF MICHIGAN

DEATH CERTIFICATE

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

John Winter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3910

03904

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Stevenson</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stevenson Road, Stevenson, Md.</b>				d. STREET ADDRESS <b>Stevenson Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>William</b> Last <b>Caple, Sr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 2, 1894</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil Co. Carroll CO., Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles C. Caple</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Shipley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>216-10-0765</b>			
17. INFORMANT <b>Stevenson, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>several yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>28 Apr. 1961</b> , that (I) (we) last saw the deceased alive on <b>25 Apr. 1961</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul H Royse</b>				22b. DATE SIGNED <b>28 Apr 61</b>		22c. PHYSICIAN'S NAME (Type) <b>PAUL H ROYSE</b>	
22d. ADDRESS <b>1403 Foley Lane Pikesville 8, Md.</b>				22e. REC'D BY REGISTRAR <b>MAY 1 '61</b>			
22f. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>May 1, 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pikesville 8, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank A. Newell, Pikesville 8,</b>				25. DATE <b>MAY 1 '61</b>			

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03905

3911

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson, Md.</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stevenson, Md.</b>				d. STREET ADDRESS <b>Stevenson Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Vivin</b> Last <b>Carey, Sr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1896</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>64</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltio.Co.Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Stevenson, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Edward Carey</b>				14. MOTHER'S MAIDEN NAME <b>Martha Simons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-4990</b>		17. INFORMANT <b>Mrs. Ida Mae Carey, Stevenson Rd.,</b>		Address <b>Stevenson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Angina</b> DUE TO (c) <b>Arteriosclerotic C-V Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>4 yrs.</b> <b>7 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 19, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jessups Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville, Md.</b>				24a. REC'D BY REGISTRAR <b>PR 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



65205

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE  
1901

NAME  
M

1

DECEASED

Form with multiple sections for medical examination, including fields for name, date, and medical history. The form is partially filled out with handwritten text and includes checkboxes for various conditions.

NAME: M  
DATE: 1901  
DECEASED

Medical history section includes checkboxes for various conditions:

- ☐ Heart
- ☐ Lungs
- ☐ Liver
- ☐ Kidneys
- ☐ Stomach
- ☐ Intestines
- ☐ Bladder
- ☐ Prostate
- ☐ Testes
- ☐ Ovaries
- ☐ Uterus
- ☐ Vagina
- ☐ Cervix
- ☐ Fallopian
- ☐ Tubes
- ☐ Endometrium
- ☐ Myometrium
- ☐ Perimetrium
- ☐ Decidua
- ☐ Placenta
- ☐ Cord
- ☐ Membranes
- ☐ Fetus
- ☐ Infant
- ☐ Child
- ☐ Adult
- ☐ Elderly
- ☐ Male
- ☐ Female
- ☐ White
- ☐ Black
- ☐ Other



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3912

03906

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>32 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>605 W. 39th St. -11</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) <b>EDGAR W. CARR</b>		<b>4. DATE OF DEATH</b> Last <b>April</b> Month <b>22</b> Day <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 20, 1892</b>

<b>9. AGE</b> (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Insurance Underwriter</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Insurance</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
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<b>13. FATHER'S NAME</b> <b>Alexander O. Carr</b>	<b>14. MOTHER'S MAIDEN NAME</b> <b>Katherine Hamilton</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW-1</b>	<b>16. SOCIAL SECURITY NO.</b> <b>WW-1</b>	<b>17. INFORMANT</b> <b>Clinical Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md. FORT HOWARD DIVISION</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> (b) <b>CEREBROVASCULAR ACCIDENT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>RECENT</b>
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>

**21. I certify** that ☒ (this hospital) attended the deceased from **March 21, 1961** to **April 22, 1961**, that ☒ (we) last saw the deceased alive on **April 22, 1961**, and that death occurred at **8:15 P.M.** from the causes and on the date stated above.

<b>22a. SIGNATURE</b> <i>M. Lawrence Rubin</i>	<b>22b. DATE SIGNED</b> <b>4/22/61</b>
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>M. LAWRENCE RUBIN, M.D.</b>	<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22d. ADDRESS</b> <b>VAH Baltimore 18, Md. FORT HOWARD DIVISION</b>

<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>23b. DATE THEREOF</b> <b>4-30-61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National Cemetery Fort Meyer, Virginia</b>	<b>23d. LOCATION</b> (City, town or county) (State)
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<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>William Cook-Blight, Inc. Baltimore, Md.</b>	<b>25a. REC'D BY REGISTRAR</b> <b>MAY 1 '61</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kline</i>
--	--	---

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

William Cook-Right, Inc. Baltimore, Md.

5000 Westing House

Washington National Cemetery Fort Rayer, Virginia

VAN Baltimore 18, 4. FORT RAYER DIVISION

1. FARMER HUNT, M.D.

April 22, 61

March 21, 61 April 21, 61

DEATH VASCULAR ACCIDENT

1 WEEK

RECORD

Yes

W-1

Alzheimer, J. Carl

University of Maryland

Wife

July 21, 1952

68

CAR

April

1951

Veterans Administration Hospital

105 W. 32nd St. - 11

35 days

Baltimore

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3913

CERTIFICATE OF DEATH

Item 14 Film G285 4/21/61 iwk

03907

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>40 Days</b>		d. STREET ADDRESS <b>703 Mosher Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LYMAN</b>		4. DATE OF DEATH <b>April 16, 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 2, 1889</b>	
9. AGE (in years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sash Weight Corp.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Drewrys Bluff, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lee G. Carter</b>		14. MOTHER'S MAIDEN NAME <b>Harriet unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>Clinical Rec VAH Baltimore Md -Ft Howard Div.</b>	
17. INFORMANT <b>Harriet unknown</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>CEREBRAL THROMBOSIS</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>2 MONTHS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 7, 1961</b> to <b>April 16, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 16, 1961</b> , and that death occurred at <b>3:00 a.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles E. Rowan</b>		22b. DATE SIGNED <b>4-16-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES E. ROWAN</b>		22d. ADDRESS <b>VAH Baltimore 18 Md -Ft Howard Division</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-20-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		25a. REC'D BY REGISTRAR <b>APR 18 '61</b>	
ADDRESS <b>1808-10 N Monroe St Baltimore 17, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

13-02-1

08-09-2016

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-10-2001 BY SP-6 BTJ/KJS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3914

03908

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>				c. LENGTH OF STAY IN 1b <b>21 mos. plus</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Belia</b> Last <b>Chick</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/21/77</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Records: SPRING GROVE STATE HOSPITAL</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Cardiac Failure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>December 9, 1960</b> to <b>April 19, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 19, 1961</b> and that death occurred at <b>11:59 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachslar</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar M.D.</b>							
22d. ADDRESS <b>Spring Grove State Hospital Catonsville 28, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
23b. DATE THEREOF <b>April 22, 1961</b>							
23c. NAME OF CEMETERY OR CREMATORY <b>West View Cemetery</b>							
23d. LOCATION (City, town, or county) (State) <b>Farmville Virginia</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Doynes &amp; Burger</b>							
ADDRESS <b>Catonsville Md.</b>							
25a. REC'D BY REGISTRAR <b>DATE APR 24 '61</b>							
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1916

(M)

03304

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of attending physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

13. Name of informant: \_\_\_\_\_

14. Address of informant: \_\_\_\_\_

15. Date of filing: \_\_\_\_\_

16. File number: \_\_\_\_\_

17. County: \_\_\_\_\_

18. State: \_\_\_\_\_

19. City: \_\_\_\_\_

20. Zip: \_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3915

03909

Items 18-21, Film G-287 5/15/61.cac.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6609-C Glenbar Court</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6609-C Glenbar Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>THOMAS</b> Middle <b>WEST</b> Last <b>CLAGGETT, Jr.</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>28</b> Year <b>19 61</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 18, 1910</b>	<b>9. AGE</b> (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b>  		
<b>13. FATHER'S NAME</b> <b>Thomas West Claggett</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Edna Starr</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> (If yes give number or dates of service)		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Thomas W. Claggett, 3rd.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ethyl Alcohol and Barbiturate Intoxication</b> <b>888.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					<b>INTERVAL BETWEEN ONSET AND DEATH</b>  		
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Ingestion of ethyl alcohol and barbiturates.</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>3:30</b> p.m. <b>4/27/61</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			
<b>20f. (City or town)</b> <b>Parkville, Baltimore, Md.</b>		<b>20g. (County)</b>  		<b>20h. (State)</b>  			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>Charles S. Petty</b>		<b>M.D. ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <b>4/28/61</b>			
<b>EXAMINER'S NAME</b> (Type) <b>Charles S. Petty, M.D.</b>		<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> Address (Street, city, town, or county)					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>5-1-61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Marks Church</b>			
<b>22d. LOCATION</b> (City, town, or country) (State) <b>Petersville, Maryland</b>		<b>23. FUNERAL DIRECTOR</b> <span style="float: right;">ADDRESS</span> <b>John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Place</b>					
<b>24a. REC'D BY REGISTRAR</b> <b>MAY 2 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Petty</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3916

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03910

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>				c. LENGTH OF STAY IN 1b <u>1yr7mos plus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emanuel</u> Middle <u>Colvin</u> Last <u>Colvin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/25/09</u>	
9. AGE (In years lost birth day) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>51</u> Days <u>18</u> Hours <u>18</u> Min.		IF UNDER 24 HRS. Months <u>51</u> Days <u>18</u> Hours <u>18</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joshua Colvin</u>				14. MOTHER'S MAIDEN NAME <u>Anna Rosen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>RECORDS: Spring Grove State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> (c) <u>Alzheimer's Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alzheimer's Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/21/61</u> to <u>April 28</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>April 28</u> , 19 <u>61</u> , and that death occurred at <u>4:15</u> P. M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Loretta Hsu</u>				22b. DATE <u>April 28, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Loretta Hsu M.D.</u>				22d. ADDRESS <u>Spring Grove State Hospital Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-30-61</u>		<u>High School</u>		<u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							

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CENTRAL BANK OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
3917																			
CERTIFICATE OF DEATH																			
03911																			
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>628 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>3438 Park Heights Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <b>William H. Cook</b>					4. DATE OF DEATH Month Day Year <b>April 22 19 61</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15, 1893</b>		9. AGE (In years last birthday) <b>67</b> yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Painting Contractor</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>											
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																			
13. FATHER'S NAME <b>John W. Cook</b>					14. MOTHER'S MAIDEN NAME <b>Mary B. Akers</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>					16. SOCIAL SECURITY NO. <b>213-12-4374</b>					17. INFORMANT <b>Clinical Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md. Ft. Howard Division</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA DUE TO CARCINOMA OF COLON</b> 153.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>PNEUMONIA</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 YEARS</b>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) <b>Baltimore</b>					20g. (County) <b>Baltimore</b>					20h. (State) <b>Maryland</b>									
21. I certify that (If this hospital) attended the deceased from <b>August 3, 19 59</b> to <b>April 22, 19 61</b> , that (we) last saw the deceased alive on <b>April 22, 19 61</b> , and that death occurred <b>10:20AM</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>M. Lawrence Rubin</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>4/22/61</b>					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <b>M. LAWRENCE RUBIN, M. D.</b>					22d. ADDRESS <b>VAH, BALTO. 18, MD. FT HOWARD DIVISION</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>4/26/61</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>									
23d. LOCATION (City, town or county) <b>Baltimore 28, Maryland</b>																			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm-Cook Blight, Ind. 6009 Harford Rd. Balto 14, Md.</b>					ADDRESS <b>APR 25 '61</b>					25a. REC'D BY REGISTRAR <b>Arthur S. Evans</b>									
25b. REGISTRAR'S SIGNATURE																			

03011

03011

(M)

WANTLAND

WANTLAND

HASTINGS

458 458

FOOT BOARD

3108 Park Heights Avenue

VETERANS ADMINISTRATION BUILDING

April 12

Book

William

October 12, 1892

White

White

U.S.A.

Technical Committee, Baltimore, Maryland

at

Harry D. Adams

John W. Cook

(1)

Clinical Research, VII, 3900 Loan Haven

401-12-1071 Blvd. Baltimore, Md. 77. Housing Division

1911

1911

8 YEARS

RESEARCH TO CALIFORNIA RUE TO CAROLINA BY COLEMAN

X

RESEARCH

August 12, 1911

April 12

1/23/01

VAN, BARON, 19, NO. 17 WARD DIVISION

M. L. BARON, 19, NO. 17 WARD DIVISION

Baltimore 28, Maryland

Baltimore National

4/26/01

Baltimore

U.S.A.

1911

John-Cook Bridge, 100, 6000 Maryland Rd. Baltimore, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3918

## CERTIFICATE OF DEATH

Reg. Dist. No. 03912

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>80 Frederick Rd.</u>				d. STREET ADDRESS <u>80 Frederick Rd.</u>			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>GEORGE</u> <u>CLARENCE</u> <u>CORUN</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>21</u> Year <u>1961</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 8 1878</u>	
<b>9. AGE</b> (In years, last birthday) <u>82</u> yrs.		<b>10. AGE</b> (In years, last birthday) <u>82</u> yrs.		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired</u>			
<b>13. FATHER'S NAME</b> <u>Albert Corun</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie Beach</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>218-05-3297</u>		<b>17. INFORMANT</b> <u>Paul Corun</u> Address <u>New Cut Rd, Ellicott City, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma, Cecum</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>61</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I attended the deceased from</b> <u>Feb 1</u> , 19 <u>58</u> , to <u>Apr 21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Apr 3</u> , 19 <u>61</u> , and that death occurred at <u>10:05</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4-22-61</u>							
<b>ACTUAL SIGNATURE</b> <u>Thomas F. Herbert</u> M.D.				<b>46 Church Road</b>			
<b>PHYSICIAN'S NAME (Type)</b> <u>Thomas F. Herbert, M. D.</u>				<u>Ellicott City, Maryland</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4/24/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Good Shepherd</u>		<b>22d. LOCATION (City, town, or county)</b> _____ (State) _____ <u>Ellicott City, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F.C. Higinbotham</u>				<b>ADDRESS</b> <u>Ellicott City, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>APR 24 '61</u>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>			

CERTIFICATE OF DEATH

1918

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF WITNESSES	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

2

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

23. FUNERAL DIRECTOR

Baltimore

b. CITY OR TOWN (if outside corporate limits,  
write RURAL and give nearest town)

Lansdowne

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

XXXXXXXXXXXX 103 Second Avenue

3. NAME OF  
DECEASED  
(Type or print)

Carrie Cook Coyle

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Aug. 3, 1890

9. AGE (in years  
last birthday)

70 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Home

10b. KIND OF BUSINESS OR INDUSTRY

Home duties

11. BIRTHPLACE (State or foreign country)

Penna

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Albert S. Cook

14. MOTHER'S MAIDEN NAME

Ann Snider

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Joseph M. Coyle 103 2nd Ave. 27

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute cardiac heart failure

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Cardio vascular heart disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.  
p.m.

19

20d. INJURY OCCURRED

While ☐ Not While ☐  
at work at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

DATE SIGNED

April 18, 61

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/21/61

22c. NAME OF CEMETERY OR CREMATORY

Lorraine Park Cem.

22d. LOCATION (City, town, or county)

Baltimore, Maryland

23. FUNERAL DIRECTOR

Howard H. Hubbard 4107 Wilkens Ave.

24a. REC'D BY REGISTRAR

DATE APR 24 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3919 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03913

03913

(M)

(I)

101 Second Avenue

101 Second Avenue

101 Second Avenue

Howard E. Hubbard 1107 Wilma Ave.

1  
3920

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03914

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>23 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>26 BUNCHE STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>WESTLY</b> Last <b>CULLEY</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>6</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/28/1912</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>THOMAS CULLEY</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH TURNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>YES 1942-1945</b>				16. SOCIAL SECURITY NO. <b>220-01-5972</b>			
17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Lung with Metastases</b> <b>163 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>approximately 15 days</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/5/1961</b> to <b>4/6/1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4/6/1961</b> , and that death occurred at <b>10:28 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-11-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maureen H. Campbell</b>				25a. REC'D BY REGISTRAR <b>APR 12 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

00004

CERTIFICATE OF DEATH

(M)

CHIEF OF POLICE

DEPT. OF HEALTH

1914

John J. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

3921

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03915

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u>	
c. LENGTH OF STAY IN 1b <u>30 yrs</u>		d. STREET ADDRESS <u>1728 Arlington ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1728 Arlington ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERNADETTE M. CURRAN</u>		4. DATE OF DEATH <u>April 16 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1874</u>
9. AGE (in years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph A. Curran</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth V. Williamson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. Joseph J. Curran</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary disease - myocarditis -</u> Conditions, if any, which gave rise to immediate cause (b) <u>General arterio sclerosis -</u> (a), stating the underlying cause last. (c) <u>Acute decompensation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>12 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1930</u> to <u>April 16 1961</u> , that (I) (we) last saw the deceased alive on <u>April 16 1961</u> , and that death occurred at <u>  </u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederic V. Beiter</u> M.D.		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERIC V BEITER</u>		22d. ADDRESS <u>1014 Francis Ave - Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 19, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>4905 York Road</u>		DATE <u>APR 19 '61</u>	

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Joseph A. Curran

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BERNARDINE M CURRAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 22b, Film 9284 4/5/61 jwk

CERTIFICATE OF DEATH

Reg. Dist. No.

03916

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2312 Springlake Dr.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3626 Whitehaven Pkwy</u> d. STREET ADDRESS <u>Wash D.C.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>M.</u> Last <u>Dailey</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>14</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>U.S.A. Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew J. Mau</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Arthur W. Dangar</u>		Address <u>2312 Springlake Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial degeneration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>422.2</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>metastatic carcinoma of liver</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-31, 1961</u> , to <u>4-4, 1961</u> , that I last saw the deceased alive on <u>4-3, 1961</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2308 Pat Springs Rd Tim. Md</u> DATE SIGNED <u>4-4-61</u>			
ACTUAL SIGNATURE <u>John J. Gould</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN J. GOULD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-16-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON - VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Townsend</u> ADDRESS <u>1650 YORK RD-TOWSON</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3923

03917

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>			c. LENGTH OF STAY IN 1b <b>Most of Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hollow Road, Cockeysville, Md</b>				d. STREET ADDRESS <b>1 Hollow Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Granville</b> First <b>Dawson</b> Middle Last				4. DATE OF DEATH <b>April</b> Month <b>29</b> Day <b>1961</b> Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-29-1908</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Co. Metro. Dist.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry Dawson</b>				14. MOTHER'S MAIDEN NAME <b>Blanche ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>232-26-5843</b>		17. INFORMANT Address <b>Mrs J. Howard Hollow Rd Cockeysville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH <b>1 inmediate</b> <b>12 yrs.</b>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>60</b> , to <b>April</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>April 12 1961</b> , and that death occurred at <b>6:35 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Elizabeth B. Sherrill</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b>				22d. ADDRESS <b>Cockeysville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>5-2-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mays Chapel Cemetery Cockeysville</b>		23d. LOCATION (City, town, or county) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service Towson 4, Md.</b>				ADDRESS <b>DATE MAY 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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CENTRAL OF DEATH

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Brooks Transfer Service  
2-1-51  
Maya Chandel  
Cokeville, W.Va.  
July 12, 1951  
Cokeville, W.Va.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3924

3924

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03918

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <input checked="" type="checkbox"/></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>30 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2905 St. Paul Street</b>			
3. NAME OF DECEASED (Type or print) <b>LOUIS W. DEHLER</b>				4. DATE OF DEATH <b>APRIL 29 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/87</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy Yard</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam Dehler</b>				14. MOTHER'S MAIDEN NAME <b>MARY (UNKNOWN)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Fort Howard Division</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE STOMACH WITH METASTASES TO LIVER</b> <b>151X XXXX PANCREAS, GALL-BLADDER, LUNGS AND MEDIASTINAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>XX NODES</b> DUE TO (c)						UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>POLYCYSTIC KIDNEYS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 30 1961</b> to <b>April 29 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 29 1961</b> , and that death occurred at <b>11:20 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Donald W. Stewart</b> M.D. <b>DONALD W. STEWART, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD W. STEWART, M.D.</b>				22d. ADDRESS <b>VAH, BALTO. MD. FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-3-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, Inc.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 4 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

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U.S. DEPT. OF JUSTICE

JOHN A. W. STEWART, JR.

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Edward J. Mack, Inc.  
Baltimore, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3925

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03919

1. PLACE OF DEATH a. COUNTY <i>Balt</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <i>Md</i> b. COUNTY <i>Balt</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>		c. LENGTH OF STAY IN 1b <i>9 mo</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>395 Buttr Rd.</i>				d. STREET ADDRESS <i>1 395 Buttr Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>DOUGLAS GREG DELBAUGH</i>				4. DATE OF DEATH Month <i>Apr</i> Day <i>17</i> Year <i>1961</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 18, 1960</i>	9. AGE (In years last birthday) yrs. <i>4</i>	IF UNDER 1 YEAR Months <i>4</i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Hannover, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm F. Delbaugh</i>				14. MOTHER'S MAIDEN NAME <i>Dorothy Atkinson</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mrs Dorothy Delbaugh - Reisterstown</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Pneumonia</i> 493X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <i>Congenital deformity Rt side of nose</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>None</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>D.D. Caples</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<i>4-17-61</i>	
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 19, 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>West Side Cemetery</i>		22d. LOCATION (City, town, or country) (State) <i>Shomokin Dam, Pa.</i>	
23. FUNERAL DIRECTOR <i>J.F. Eline &amp; Sons, Reisterstown, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>APR 19 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

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10025 - NATIONAL STAMPER'S CERTIFICATE OF DEATH

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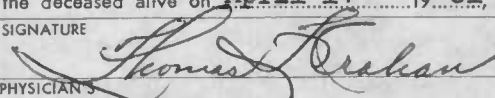
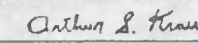
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3926

03920

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>753 West Baltimore Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ADEN M. DELLINGER</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>14</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>April 18, 1896</b> <b>9. AGE</b> (In years last birthday) <b>64</b> yrs. <b>10. IF UNDER 1 YEAR</b> Months _____ Days _____ <b>11. IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Mechanic</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Automobile Garage</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Mount Jackson, Virginia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>John F. Dellinger</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Minnie Lee Grim</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW I</b> <b>16. SOCIAL SECURITY NO.</b> <b>WW I</b>		<b>17. INFORMANT</b> <b>Clin Records, VAH, Balto. Md. Ft. Howard, Div.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TUBERCULOSIS OF THE LUNG, FAR ADVANCED,</b> DUE TO <b>ACTIVITY UNDETERMINED</b> (b) _____ Conditions, if any, which gave rise to immediate cause (c) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>April 10, 1961, April 14, 1961</b>			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 1961, to _____, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 14, 1961</b> , and that death occurred at _____, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M. D.</b>				<b>22b. DATE SIGNED</b> <b>April 14, 1961</b> <b>22d. ADDRESS</b> <b>VAH, BALTO. MD. FT HOWARD DIVISION</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>4-14-61</b>		<b>23b. DATE THEREOF</b> <b>4-14-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Massanutten Cemetery</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Woodstock, Virginia</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>William Cook Blight Inc. 6009 Harford Road, Baltimore, Md.</b>					
<b>25a. REC'D BY REGISTRAR</b> DATE <b>APR 17 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



120

THE  
NATIONAL  
FIRE  
PROTECTION  
ASSOCIATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3927

03921

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ashland</b> c. LENGTH OF STAY IN lb <b>Ashland</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ashland Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ashland</b> d. STREET ADDRESS <b>Ashland Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>HARRISON GILMORE DENMYER</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>April 26, 19 61</b> Month Day Year				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>March 12, 1887</b>		<b>9. AGE</b> (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer- retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>General labor</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Unknown</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>None</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-10-5308</b>		<b>17. INFORMANT</b> <b>Family records</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial - Chronic</b> DUE TO (b) <b>hypertension</b> DUE TO (c) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from 4-26-61 to 4-26-61, that (I) (we) last saw the deceased alive on 4-26-61, and that death occurred at 4-26-61, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>James G. Saffell</i>				<b>22b. DATE SIGNED</b> <b>4-29-61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>James G. Saffell</b>				<b>22d. ADDRESS</b> <b>Reisterstown Md</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>April 29, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Moreland Memorial Cemetery</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Parkville, Maryland</b> (State)							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John Burns' Sons, Towson, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>MAY 1 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Thomas</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



03021

Beltsville	Maryland	Beltsville
Ashland	Ashland	Ashland
Ashland Road	Ashland Road	Ashland Road
April 26, 1937	HARRISON GILMORE DENNY	
74	March 12, 1937	White
USA	Maryland	General Labor
Unknown	Unknown	Unknown
Family records	218-10-508	None

April 26, 1902 Moreland Hospital Cemetery Lexington, Maryland  
John Burns' Sons, Towson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Tenn  
144 E. 10th Road  
Denton

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144 E. 10th Road  
Paul Misset

MARYLAND

SALES TRAINING MGR. CO. INC.

Family Records

No

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W. GRANT HEASLER  
144 E. 10th Road  
Denton, Tenn

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03923

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>8yr7mth16dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>S pring Grove State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Ann</b> Last <b>DePro</b>				4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 1, 1876</b>	
9. AGE (In years lost birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John H. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Gibson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: Spring Grove State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterine cervix</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Chronic Brain Syndrome associated with generalized arteriosclerosis</b> DUE TO lying cause last. (c) <b>Chronic Brain Syndrome Assoc. with Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Assoc. with Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>171X</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1</b> 19 <b>60</b> to <b>April 22</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>April 22 1961</b> , and that death occurred <b>4:14 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Jose R. Arizaga</b>				22b. DATE SIGNED <b>April 22, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Jose R. Arizaga, M.D.</b>				22d. ADDRESS <b>Spring Grove State Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION (City, town, or county) <b>Balto.</b> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING  
may be retained by the hospital  
or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3930

**CERTIFICATE OF DEATH**

Item 7, Film G 308

03924

Item 9 Film 0285

4/24/61 1wk 3/12/62 1ml

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10yr9mth17dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>105 Fifth Street</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>P.</b> Last <b>DeWald</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1909</b>
9. AGE (In years last birthday) <b>51 52 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>contracting</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George G. DeWald</b>		14. MOTHER'S MAIDEN NAME <b>Bessie King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-05-9107</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1952</b> to <b>April 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1961</b> , and that death occurred at <b>8:15 A. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachler</b>		22b. DATE SIGNED <b>4-7-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 8, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Laurel, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. W. Donaldson</b>		25a. REC'D BY REGISTRAR <b>APR 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>			

MEDICAL CERTIFICATION

the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0388

0388

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3931

03925

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2yr4mth19dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Dolan</b> Last <b>Dolan</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 61</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1888?</b>	
9. AGE (In years last birthday) <b>72? yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 9 19 58</b> to <b>April 28 19 61</b> , that (I) (we) last saw the deceased alive on <b>April 28 19 61</b> , and that death occurred at <b>12:20 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachsler</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>5-2-61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>5/3/61</b>		<b>Cathedral</b>		<b>4300 Old Frederick</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>G. J. Faley Sons</b>				ADDRESS <b>1318 Light</b>		25a. REC'D BY REGISTRAR <b>MAY 3 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>	

03035

03035

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King's Highway

1. The first of the three main roads is the King's Highway, which runs from the north to the south of the island. It is the main road for the transport of goods and passengers. The second road is the main road from the west to the east, and the third road is the main road from the south to the north.

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3932  
CERTIFICATE OF DEATH  
03926

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>13yr9mo +</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Yaggie</b> Last <b>Downey</b>		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1897</b>
9. AGE (In years, months, days) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>03</b> Days <b>00</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Yagge</b>		14. MOTHER'S MAIDEN NAME <b>Catherine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Terminal uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Congestive heart failure</b> DUE TO (c) <b>arteriosclerotic cardiovascular disease with hypertension.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>23 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1961</b> to <b>April 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1961</b> , and that death occurred at <b>6:11 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Aristides Simopoulos</b>		22b. DATE SIGNED <b>April 27, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aristides Simopoulos</b>		22d. ADDRESS <b>Spring Grove State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/1/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
25a. REC'D BY REGISTRAR <b>DATE APR 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

83286

CERTIFICATE OF DEATH

(M)

(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

3933

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03927

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 Norris Lane		d. STREET ADDRESS 707 Norris Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DAVID W. DUDLEY		4. DATE OF DEATH Month Day Year April 3, 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1901
9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Board of Education	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel I. Dudley		14. MOTHER'S MAIDEN NAME Mabel Hines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 111-12-4539	
17. INFORMANT Ida Maye Dudley		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 4-3-61 to 4-3-1961, that (I) (we) last saw the deceased alive on 4-3-61 19, and that death occurred at 8:45 PM, from the causes and on the date stated above. 22a. SIGNATURE John E. Gesser M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 701 Eastern Avenue Md. 22b. DATE SIGNED 4-4-61			INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS?
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/61	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdinski		25a. REC'D BY REGISTRAR DATE APR 5 '61	
ADDRESS 1407 Eastern Ave. #21		25b. REGISTRAR'S SIGNATURE	

03231

CERTIFICATE OF DEATH

0323

(M)

Causes of Death

18-5-41  
John E. Anderson

1941-5-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3934

03928

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6511 Sherwood Road</b>		d. STREET ADDRESS <b>6511 Sherwood Road</b>	
3. NAME OF DECEASED (Type or print) <b>RUTH S EBERLING</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1920</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>40</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George S. Sawyer</b>		14. MOTHER'S MAIDEN NAME <b>Annie L. Ashbourne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Robert C. Eberling</b>	
17. INFORMANT <b>Robert C. Eberling</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>170X FROM CARCINOMA OF LEFT BREAST</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>9 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT. 28, 1958</b> , to <b>APRIL 18, 1961</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>APRIL 18, 1961</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry J. Jenkins</b>		22b. DATE SIGNED <b>APRIL 19, 1961</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>7215 YORK RD BALTIMORE 12, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 21, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Woodlawn Balto. Co, Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons, Co.</b>		25. REC'D BY REGISTRAR <b>4905 York Road</b>	
15M 9/60		DATE <b>APR 19 '61</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3935

03929

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>135 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>10 N. Monroe Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Alexander N. Edemy</b>			4. DATE OF DEATH <b>April 20 1961</b>					
5. SEX <b>Male</b>			6. COLOR OR RACE <b>Negro</b>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <b>September 13, 1921</b>					
9. AGE (In years last birthday) <b>39 yrs.</b>			10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>					
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Alexander N. Edemy</b>			14. MOTHER'S MAIDEN NAME <b>Maude Fisher</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>			16. SOCIAL SECURITY NO. <b>216-14-5482</b>					
17. INFORMANT <b>Clin. Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md. Fort Howard Division</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>434.4</b> (b) <b>COR PULMONALE</b> (c) <b>SARCOTIDOSIS, PULMONARY</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Monilia Infection, Gastric Ulcer</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>7 years</b> <b>7 years</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 6, 1960</b> to <b>April 20, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 20, 1961</b> , and that death occurred at <b>10:00 PM</b> from the causes and on the date stated above.								
22a. SIGNATURE <b>Joseph J. Cillo M.D.</b>			22b. DATE SIGNED <b>4/23/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH J. CILLO, M.D.</b>			22d. ADDRESS <b>VAH, Balto. Md. Ft. Howard Division</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-25-61</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore 28, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>			25a. REC'D BY REGISTRAR <b>APR 26 '61</b>					
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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3936  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03930

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowleys Quarters</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2019 Oakland Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Veirs</u> Last <u>Edwards</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Biddison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Anna Ricords</u>		Address <u>2019 Oakland Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>PROSTATE</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1, 1951</u> to <u>APR. 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>APR 21, 1961</u> , and that death occurred at <u>4:15 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Miceli</u>		22b. DATE SIGNED <u>4/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>		22d. ADDRESS <u>108 S. TAYLOR AVE BALTO 2 MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-25-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Orems Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lester J. Hong</u>		25a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Curtis S. Thomas</u>			

03080

CERTIFICATE OF DEATH

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James M. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03931

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Middle River</u> b. COUNTY <u>Balto. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2123 Oakland Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Beatrice M. Egner</u>				4. DATE OF DEATH <u>4 25 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles W. Pick</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Fair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-2331</u>		17. INFORMANT <u>Mr Otto Egner 2123 Oakland Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of sigmoid colon</u> 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 years</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> to <u>April 25 1961</u> , that (I) (we) last saw the deceased alive on <u>April 25 1961</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Louis Sernanoff</u>		22b. DATE, SIGNED <u>4/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SERENOFF</u>		22d. ADDRESS <u>2108 CREMS RD, BALTO 20 MD</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>2108 CREMS RD, BALTO 20 MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-28-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City, town, or county) (State) <u>Parkville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassala Funeral Home 7401 Belair Road</u>				25a. REC'D BY REGISTRAR <u>DATE APR 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaas</u>	

03030

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

3938

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03932

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>7-25-60</u> X <u>Ruston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor - Seminary Ave</u>		d. STREET ADDRESS <u>16516 Darnall Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>hou</u> Last <u>Eisele</u>		4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-71</u>	
9. AGE (In years lost birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Klopfer</u>		14. MOTHER'S MAIDEN NAME <u>Houise Hahn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>C. Pressmann Rn.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis and</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> <u>1960</u> , to <u>4/2</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>3/30</u> <u>1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Franklin E. Leslie</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Franklin E. Leslie</u>		22d. ADDRESS <u>2929 N. Charles St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial April 5, 1961</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Roslyn, Penna.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03933

Reg. Dist. No.

3939

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2808 Pelham Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>G. L. Martin Co.</b>		d. STREET ADDRESS <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>ANDREW WILLIAM ENDRES</b>		4. DATE OF DEATH Month <b>4</b> - Day <b>20</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/1899</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Endres</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Hoffman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>WW1</b>		16. SOCIAL SECURITY NO. <b>213-10-1439</b>	
17. INFORMANT <b>Theresa Diepold Endres, wife, above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>A-S-C-V Disease</b> (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. Brown</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles E. Schimunek</b>		DATE SIGNED <b>4/21/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/24/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>		24a. REC'D BY REGISTRAR DATE <b>APR 24 '61</b>	
ADDRESS <b>3331 Brehms Lane</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing a word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03833

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3940

03934

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>1 yr?</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle <b>Irving</b> Last <b>Ensor</b>				<b>4. DATE OF DEATH</b> Month <b>4</b> Day <b>27</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-31-1867</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner, operator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph E. Ensor</b>				14. MOTHER'S MAIDEN NAME <b>M. Tracy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>J. Irving Ensor Jr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</b> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>8 YRS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>April 27, 1961</b> , that (I) (we) lost saw the deceased alive on <b>April 26, 1961</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William A. Pillsbury</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-28-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William A. Pillsbury</b>				22d. ADDRESS <b>2060 YORK RD. TIMONIAN MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-29-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Black Rock</b>		23d. LOCATION (City, town, or county) (State) <b>Butler Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service Towson 4, Md.</b>				ADDRESS <b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

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CHIEF OF POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03935

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>				c. LENGTH OF STAY IN 1b <b>31 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>40 Portship Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>(NMN)</b> Last <b>EVANS</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24th</b> Year <b>19 61</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1899</b>	
9. AGE (In years last birthday) yrs. <b>61</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Open Hearth</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>David J. Evans</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth James</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-4332</b>		17. INFORMANT Address <b>Mrs. Laura P. Evans same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNGS</b> DUE TO <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTH</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/10</b> , 19 <b>61</b> , to <b>4/24</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>4/19</b> , 19 <b>61</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3401 Dundalk Avenue</b> DATE SIGNED <b>4/25/61</b>							
ACTUAL SIGNATURE <b>W.E. Baermann</b> M.D.				DATE SIGNED <b>4/25/61</b>			
PHYSICIAN'S NAME (Type) <b>W.E. Baermann, M.D.</b>				Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/27/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Christina S. Evans</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1938

1938

Name (Print Name)		Sex		Age		Date of Birth	
David L. Brown		Male		White		11.11.1899	
Place of Birth		Race		Color		Date of Death	
Baltimore, Maryland		Caucasian		White		11.11.1938	
Usual Residence		Cause of Death		Manner of Death		Place of Death	
Baltimore, Maryland		Heart Disease		Natural		Baltimore, Maryland	
Occupation		Disease or Injury		Immediate Cause		Underlying Cause	
Steel		Coronary Atherosclerosis		Myocardial Infarction		Coronary Atherosclerosis	
Education		Duration of Illness		Time of Day		Time of Year	
High School		Several Days		11:00 AM		November	
Marital Status		Physician		Hospital		Burial or Disposition	
Married		Dr. J. H. Smith		St. Mary's Hospital		Buried in St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness	
J. H. Smith, M.D.		David L. Brown		David L. Brown		David L. Brown	
Print Name		Print Name		Print Name		Print Name	
David L. Brown		David L. Brown		David L. Brown		David L. Brown	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03936

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>X Sparrows Point</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1341 Beechwood Road</b>		d. STREET ADDRESS <b>1341 Beechwood Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>E.</b> Last <b>EWING</b>		4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1912</b>
9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph L. Ewing</b>		14. MOTHER'S MAIDEN NAME <b>Alice Bertram</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Mrs. Elleta Ewing 718 S. 51st St.</b>	
17. INFORMANT <b>Mrs. Elleta Ewing 718 S. 51st St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Coronary arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 hrs</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 10, 1961</b> to <b>April 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 21, 1961</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John U. Conway</b>		22b. DATE <b>4-25-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John U. Conway, M.D.</b>		22d. ADDRESS <b>914 D STREET - BALTO. 19 MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/26/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 27 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

93038

CERTIFICATE OF DEATH

(M)

(J)

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03937

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1428 N. Forest Park Ave</u>				d. STREET ADDRESS <u>1428 N. Forest Park Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jessie C.</u> Middle <u>Fallice</u> Last <u>Fallice</u>				4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/25/1889</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Aloysius Welsh</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Mr Frank J. Fallice</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vas. disease.</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 12</u> , 19 <u>61</u> , to <u>Mar 22</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Mar 12</u> , 19 <u>61</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles Tommasello</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/11/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Tommasello</u>				22d. ADDRESS <u>910 W. Lombard St.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cronan &amp; Son</u>				ADDRESS <u>2 Hollins St.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 12 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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Reg. Dist. No. 03938

3944

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>X</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glen Falls Road</b>				d. STREET ADDRESS <b>Glen Falls Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>M.</b> Last <b>Fisher</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> , Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 24, 1900</b>		9. AGE (In years lost birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employed by Baltimore County</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Ernest Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Whitcomb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Mrs. Bertha L. Fisher, Reisterstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia (terminal)</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma stomach</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 5, 1960</b> , to <b>April 16, 1961</b> , that I last saw the deceased alive on <b>April 15, 1961</b> , and that death occurred at <b>1210A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Main Street</b> DATE SIGNED <b>4-17-61</b> ACTUAL SIGNATURE <b>Martin E. Strobel</b> M.D. <b>Reisterstown, Maryland</b> PHYSICIAN'S NAME (Type) <b>Martin E. Strobel, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 19/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Emory Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03038

CERTIFICATE OF DEATH

2024

1

1

6 months

Interment (burial)

Cordons attached

April 10

1900

10

April 10

11-11-01

18 Main Street

Arthur H. Strobel, M.D., Halespaw, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3945

03939

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7800 OAK AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>BLANCHE</u> Last <u>Flickinger</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1873</u>	9. AGE (in years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>(Unknown) Sullivan</u>				14. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>				16. SOCIAL SECURITY NO. <u>037010127A</u>			
17. INFORMANT <u>Howard R. Flickinger</u>				Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal dis.</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>none</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> to <u>Apr 14</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Apr 10</u> , 19 <u>61</u> , and that death occurred <u>Apr 14</u> , 19 <u>61</u> , from the causes end on the date stated above.							
22a. SIGNATURE <u>A. M. Bacon</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>				22d. ADDRESS <u>2810 Taylor Ave.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-17-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				25a. REC'D BY REGISTRAR <u>APR 17 '61</u>			
ADDRESS <u>5305 Harford Rd.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

VR A15 (4)  
15M 9/60

08030

7-17-1

08030

(M)

(I)

08030

7-17-1

08030

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

3946  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03940

1. PLACE OF DEATH o. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>519 Maryland Ave</i>		d. STREET ADDRESS <i>1 519 Maryland Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>SAMUEL C. FOSTER</i>		4. DATE OF DEATH <i>April 5th 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 27-1888</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Standard Oil Co</i>	11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Samuel C. Foster</i>		14. MOTHER'S MAIDEN NAME <i>Mary Cheske</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-03-6384</i>	
17. INFORMANT <i>Anna Foster (wife)</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Jack C Collins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JACK C Collins</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <i>4-8-61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 11-1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cem.</i>
22d. LOCATION (City, town, or county) <i>Balto</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John B. Connolly</i>		ADDRESS <i>418 Eastern Blvd 21 Md.</i>	
24a. REC'D BY REGISTRAR <i>APR 11 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03200

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. OCCUPATION		8. MARITAL STATUS		9. EDUCATION		10. RELIGION		11. SOCIAL CLASS		12. PLACE OF DEATH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH		16. CAUSE OF DEATH		17. MANNER OF DEATH		18. SIGNATURE OF MEDICAL EXAMINER	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF CORONER	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF NURSE		29. SIGNATURE OF CHURCH		30. SIGNATURE OF SCHOOL	
31. SIGNATURE OF TOWN		32. SIGNATURE OF COUNTY		33. SIGNATURE OF STATE		34. SIGNATURE OF UNION		35. SIGNATURE OF WORLD		36. SIGNATURE OF FUTURE	
37. SIGNATURE OF PAST		38. SIGNATURE OF PRESENT		39. SIGNATURE OF FUTURE		40. SIGNATURE OF DECEASED		41. SIGNATURE OF NEXT OF KIN		42. SIGNATURE OF PHYSICIAN	
43. SIGNATURE OF NURSE		44. SIGNATURE OF CHURCH		45. SIGNATURE OF SCHOOL		46. SIGNATURE OF TOWN		47. SIGNATURE OF COUNTY		48. SIGNATURE OF STATE	
49. SIGNATURE OF UNION		50. SIGNATURE OF WORLD		51. SIGNATURE OF FUTURE		52. SIGNATURE OF PAST		53. SIGNATURE OF PRESENT		54. SIGNATURE OF FUTURE	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN		57. SIGNATURE OF PHYSICIAN		58. SIGNATURE OF NURSE		59. SIGNATURE OF CHURCH		60. SIGNATURE OF SCHOOL	
61. SIGNATURE OF TOWN		62. SIGNATURE OF COUNTY		63. SIGNATURE OF STATE		64. SIGNATURE OF UNION		65. SIGNATURE OF WORLD		66. SIGNATURE OF FUTURE	
67. SIGNATURE OF PAST		68. SIGNATURE OF PRESENT		69. SIGNATURE OF FUTURE		70. SIGNATURE OF DECEASED		71. SIGNATURE OF NEXT OF KIN		72. SIGNATURE OF PHYSICIAN	
73. SIGNATURE OF NURSE		74. SIGNATURE OF CHURCH		75. SIGNATURE OF SCHOOL		76. SIGNATURE OF TOWN		77. SIGNATURE OF COUNTY		78. SIGNATURE OF STATE	
79. SIGNATURE OF UNION		80. SIGNATURE OF WORLD		81. SIGNATURE OF FUTURE		82. SIGNATURE OF PAST		83. SIGNATURE OF PRESENT		84. SIGNATURE OF FUTURE	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF PHYSICIAN		88. SIGNATURE OF NURSE		89. SIGNATURE OF CHURCH		90. SIGNATURE OF SCHOOL	
91. SIGNATURE OF TOWN		92. SIGNATURE OF COUNTY		93. SIGNATURE OF STATE		94. SIGNATURE OF UNION		95. SIGNATURE OF WORLD		96. SIGNATURE OF FUTURE	
97. SIGNATURE OF PAST		98. SIGNATURE OF PRESENT		99. SIGNATURE OF FUTURE		100. SIGNATURE OF DECEASED		101. SIGNATURE OF NEXT OF KIN		102. SIGNATURE OF PHYSICIAN	
103. SIGNATURE OF NURSE		104. SIGNATURE OF CHURCH		105. SIGNATURE OF SCHOOL		106. SIGNATURE OF TOWN		107. SIGNATURE OF COUNTY		108. SIGNATURE OF STATE	
109. SIGNATURE OF UNION		110. SIGNATURE OF WORLD		111. SIGNATURE OF FUTURE		112. SIGNATURE OF PAST		113. SIGNATURE OF PRESENT		114. SIGNATURE OF FUTURE	
115. SIGNATURE OF DECEASED		116. SIGNATURE OF NEXT OF KIN		117. SIGNATURE OF PHYSICIAN		118. SIGNATURE OF NURSE		119. SIGNATURE OF CHURCH		120. SIGNATURE OF SCHOOL	
121. SIGNATURE OF TOWN		122. SIGNATURE OF COUNTY		123. SIGNATURE OF STATE		124. SIGNATURE OF UNION		125. SIGNATURE OF WORLD		126. SIGNATURE OF FUTURE	
127. SIGNATURE OF PAST		128. SIGNATURE OF PRESENT		129. SIGNATURE OF FUTURE		130. SIGNATURE OF DECEASED		131. SIGNATURE OF NEXT OF KIN		132. SIGNATURE OF PHYSICIAN	
133. SIGNATURE OF NURSE		134. SIGNATURE OF CHURCH		135. SIGNATURE OF SCHOOL		136. SIGNATURE OF TOWN		137. SIGNATURE OF COUNTY		138. SIGNATURE OF STATE	
139. SIGNATURE OF UNION		140. SIGNATURE OF WORLD		141. SIGNATURE OF FUTURE		142. SIGNATURE OF PAST		143. SIGNATURE OF PRESENT		144. SIGNATURE OF FUTURE	
145. SIGNATURE OF DECEASED		146. SIGNATURE OF NEXT OF KIN		147. SIGNATURE OF PHYSICIAN		148. SIGNATURE OF NURSE		149. SIGNATURE OF CHURCH		150. SIGNATURE OF SCHOOL	
151. SIGNATURE OF TOWN		152. SIGNATURE OF COUNTY		153. SIGNATURE OF STATE		154. SIGNATURE OF UNION		155. SIGNATURE OF WORLD		156. SIGNATURE OF FUTURE	
157. SIGNATURE OF PAST		158. SIGNATURE OF PRESENT		159. SIGNATURE OF FUTURE		160. SIGNATURE OF DECEASED		161. SIGNATURE OF NEXT OF KIN		162. SIGNATURE OF PHYSICIAN	
163. SIGNATURE OF NURSE		164. SIGNATURE OF CHURCH		165. SIGNATURE OF SCHOOL		166. SIGNATURE OF TOWN		167. SIGNATURE OF COUNTY		168. SIGNATURE OF STATE	
169. SIGNATURE OF UNION		170. SIGNATURE OF WORLD		171. SIGNATURE OF FUTURE		172. SIGNATURE OF PAST		173. SIGNATURE OF PRESENT		174. SIGNATURE OF FUTURE	
175. SIGNATURE OF DECEASED		176. SIGNATURE OF NEXT OF KIN		177. SIGNATURE OF PHYSICIAN		178. SIGNATURE OF NURSE		179. SIGNATURE OF CHURCH		180. SIGNATURE OF SCHOOL	
181. SIGNATURE OF TOWN		182. SIGNATURE OF COUNTY		183. SIGNATURE OF STATE		184. SIGNATURE OF UNION		185. SIGNATURE OF WORLD		186. SIGNATURE OF FUTURE	
187. SIGNATURE OF PAST		188. SIGNATURE OF PRESENT		189. SIGNATURE OF FUTURE		190. SIGNATURE OF DECEASED		191. SIGNATURE OF NEXT OF KIN		192. SIGNATURE OF PHYSICIAN	
193. SIGNATURE OF NURSE		194. SIGNATURE OF CHURCH		195. SIGNATURE OF SCHOOL		196. SIGNATURE OF TOWN		197. SIGNATURE OF COUNTY		198. SIGNATURE OF STATE	
199. SIGNATURE OF UNION		200. SIGNATURE OF WORLD		201. SIGNATURE OF FUTURE		202. SIGNATURE OF PAST		203. SIGNATURE OF PRESENT		204. SIGNATURE OF FUTURE	
205. SIGNATURE OF DECEASED		206. SIGNATURE OF NEXT OF KIN		207. SIGNATURE OF PHYSICIAN		208. SIGNATURE OF NURSE		209. SIGNATURE OF CHURCH		210. SIGNATURE OF SCHOOL	
211. SIGNATURE OF TOWN		212. SIGNATURE OF COUNTY		213. SIGNATURE OF STATE		214. SIGNATURE OF UNION		215. SIGNATURE OF WORLD		216. SIGNATURE OF FUTURE	
217. SIGNATURE OF PAST		218. SIGNATURE OF PRESENT		219. SIGNATURE OF FUTURE		220. SIGNATURE OF DECEASED		221. SIGNATURE OF NEXT OF KIN		222. SIGNATURE OF PHYSICIAN	
223. SIGNATURE OF NURSE		224. SIGNATURE OF CHURCH		225. SIGNATURE OF SCHOOL		226. SIGNATURE OF TOWN		227. SIGNATURE OF COUNTY		228. SIGNATURE OF STATE	
229. SIGNATURE OF UNION		230. SIGNATURE OF WORLD		231. SIGNATURE OF FUTURE		232. SIGNATURE OF PAST		233. SIGNATURE OF PRESENT		234. SIGNATURE OF FUTURE	
235. SIGNATURE OF DECEASED		236. SIGNATURE OF NEXT OF KIN		237. SIGNATURE OF PHYSICIAN		238. SIGNATURE OF NURSE		239. SIGNATURE OF CHURCH		240. SIGNATURE OF SCHOOL	
241. SIGNATURE OF TOWN		242. SIGNATURE OF COUNTY		243. SIGNATURE OF STATE		244. SIGNATURE OF UNION		245. SIGNATURE OF WORLD		246. SIGNATURE OF FUTURE	
247. SIGNATURE OF PAST		248. SIGNATURE OF PRESENT		249. SIGNATURE OF FUTURE		250. SIGNATURE OF DECEASED		251. SIGNATURE OF NEXT OF KIN		252. SIGNATURE OF PHYSICIAN	
253. SIGNATURE OF NURSE		254. SIGNATURE OF CHURCH		255. SIGNATURE OF SCHOOL		256. SIGNATURE OF TOWN		257. SIGNATURE OF COUNTY		258. SIGNATURE OF STATE	
259. SIGNATURE OF UNION		260. SIGNATURE OF WORLD		261. SIGNATURE OF FUTURE		262. SIGNATURE OF PAST		263. SIGNATURE OF PRESENT		264. SIGNATURE OF FUTURE	
265. SIGNATURE OF DECEASED		266. SIGNATURE OF NEXT OF KIN		267. SIGNATURE OF PHYSICIAN		268. SIGNATURE OF NURSE		269. SIGNATURE OF CHURCH		270. SIGNATURE OF SCHOOL	
271. SIGNATURE OF TOWN		272. SIGNATURE OF COUNTY		273. SIGNATURE OF STATE		274. SIGNATURE OF UNION		275. SIGNATURE OF WORLD		276. SIGNATURE OF FUTURE	
277. SIGNATURE OF PAST		278. SIGNATURE OF PRESENT		279. SIGNATURE OF FUTURE		280. SIGNATURE OF DECEASED		281. SIGNATURE OF NEXT OF KIN		282. SIGNATURE OF PHYSICIAN	
283. SIGNATURE OF NURSE		284. SIGNATURE OF CHURCH		285. SIGNATURE OF SCHOOL		286. SIGNATURE OF TOWN		287. SIGNATURE OF COUNTY		288. SIGNATURE OF STATE	
289. SIGNATURE OF UNION		290. SIGNATURE OF WORLD		291. SIGNATURE OF FUTURE		292. SIGNATURE OF PAST		293. SIGNATURE OF PRESENT		294. SIGNATURE OF FUTURE	
295. SIGNATURE OF DECEASED		296. SIGNATURE OF NEXT OF KIN		297. SIGNATURE OF PHYSICIAN		298. SIGNATURE OF NURSE		299. SIGNATURE OF CHURCH		300. SIGNATURE OF SCHOOL	

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3947

03941

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cowenton</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 1069 Red Lion Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>P.</u> Last <u>Francis</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-28-1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Proctor</u>				14. MOTHER'S MAIDEN NAME <u>Addie Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>J. Proctor Francis</u> Address <u>Box 1069 Red Lion Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis.</u> DUE TO (b) <u>Arteriosclerosis.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> 19 <u>59</u> to <u>4/20</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> 19 <u>61</u> and that death occurred at <u>1A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel Stern</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Samuel STERN.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Camp Chapel Methodist</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Stern 74015 Balto Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

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RECEIVED AT DEPARTMENT OF HEALTH  
OFFICE OF THE SECRETARY  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03942

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>8732 OLD HARFORD ROAD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8732 OLD HARFORD ROAD PARKVILLE</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8732 OLD HARFORD ROAD</u>		d. STREET ADDRESS <u>8732 OLD HARFORD RD.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>RHODA</u> Middle <u>E</u> Last <u>FRANCIS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 22 1878</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN L JAMES</u>		14. MOTHER'S MAIDEN NAME <u>CLARA COLE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>CHARLES FRANCIS 8732 OLD HARFORD RD.</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertensive chronic arterial cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>14 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> 19 <u>56</u> to <u>April</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March</u> 19 <u>61</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.				
22a. SIGNATURE <u>William Harris</u>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 10, 1961</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>CAMP CHAPEL</u>		23d. LOCATION (City, town, or county) (State) <u>PERRY HAVEN MD.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>David L. Funeral Home</u>		ADDRESS <u>7401 Belair Rd #6</u>		
25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>89 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2810 Riggs Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>THOMAS D. FREEMAN</b>					4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1961</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 18, 1918</b>		9. AGE (In years last birthday) <b>42 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef - Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Douglas Freeman</b>					14. MOTHER'S MAIDEN NAME <b>Bessie Thomas</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>					16. SOCIAL SECURITY NO. <b>218-22-4669</b>		17. INFORMANT <b>Clin. Records, VAM, Balto 18, Md. Fort Howard Division</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>5 222 XXXX CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>XXXXX ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS WITH KIMMELSTEIL-WILSON DISEASE AND NEUROPATHIES</b>								INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>UNKNOWN</b> <b>YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>January 24, 1961 to April 23, 1961</b>		20g. (County) <b>BALTIMORE</b>	
20h. (State) <b>MD.</b>		20i. (City or town) <b>BALTIMORE</b>		20j. (County) <b>BALTIMORE</b>		20k. (State) <b>MD.</b>		20l. (City or town) <b>BALTIMORE</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 24, 1961 to April 23, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 23, 1961</b> , and that death occurred <b>12:30 PM</b> on the causes and on the date stated above.									
22a. SIGNATURE <b>Joseph J. Cillo, M.D.</b>					22b. DATE SIGNED <b>4/23/61</b>				
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH J. CILLO, M. D.</b>					22d. ADDRESS <b>VAH, BALTO. MD. FT HOWARD DIV.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-27-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City, town or county) <b>BALTIMORE 28, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. JOHNSON FUNERAL HOME, 1011 N. Arlington St.</b>					25a. REC'D BY REGISTRAR <b>APR 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>		
Baltimore, Maryland									

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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**References**

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **03944**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>308 Murdock Rd. #12</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baltimore, Md.</u> d. STREET ADDRESS <u>1308 Murdock Rd. #12</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>Frish</u>				<b>4. DATE OF DEATH</b> Month <u>Apr.</u> Day <u>11</u> Year <u>1961</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 5, 1879</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Owner</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Food Merchant</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Germany</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Frederick Frish</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Marie Sohnle</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>213-10-2332</u>		<b>17. INFORMANT</b> <u>George C. Frish</u> Address <u>308 Murdock Rd. #12</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <u>July 20, 1955</u> <b>to</b> <u>April 11, 1961</u> <b>that I last saw the deceased alive on</b> <u>April 11, 1961</u> <b>and that death occurred at</b> <u>8:45 P.M.</u> <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <u>Laurence C. Post</u> <b>M.D.</b> <u>6801 York Rd</u> <b>DATE SIGNED</b> <u>4-12-61</u> <b>PHYSICIAN'S NAME (Type)</b> <u>LAURENCE C. POST</u> <u>Baltimore 12 Md</u>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4/15/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Dulaney Valley Mem. Gar.</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore Co. Md</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook-Townson Inc.</u>				<b>ADDRESS</b> <u>1050 York Rd. #4</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>APR 14 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







Page 4  
Page 3  
Page 2  
Page 1  
Page 0

1  
3951  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03945

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 57 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 1508 Eastern Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Edward Fuhrman		4. DATE OF DEATH Month Day Year 4 1 1961					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/1884	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar-tender		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George P. Fuhrman				14. MOTHER'S MAIDEN NAME Emma S. Houck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-14-0840		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic Cardiac Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002 x Far Advanced Pulmonary Tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2/3 1961 to 4/1 1961, that (I) (we) last saw the deceased alive on 4/1 1961, and that death occurred at 6:35 PM, from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-61		23c. NAME OF CEMETERY OR CREMATORY Hampstead		23d. LOCATION (City, town, or county) (State) Gensel Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Glen C. Gipton				ADDRESS Hampstead Md		25a. REC'D BY REGISTRAR DATE APR 4 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03946

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>3Yrs.6Mos.23Das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Sheppard and Enoch Pratt Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. STREET ADDRESS <b>4606 N. Charles Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Garrett</b> Last <b>Garrett</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1875</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Investment Banker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brokerage</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Garrett</b>		14. MOTHER'S MAIDEN NAME <b>Alice Whiteridge</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1917 - 1918</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Gen. arteriosclerosis</b> (b) <b>Chronic myocarditis</b> (c) <b>Gen. arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b> <b>5 yr +</b> <b>11</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. Brain Syndrome due to Senile Brain Dis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 2, 1957</b> to <b>April 25, 1961</b> that (I) (we) lost the deceased alive on <b>April 24, 1961</b> , and that death occurred on <b>April 25, 1961</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W. W. Elgin</b>		22b. DATE SIGNED <b>April 25, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. W. Elgin, M. D.</b>		22d. ADDRESS <b>Towson 4, Maryland</b> <b>The Sheppard and Enoch Pratt Hospital,</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co., Inc</b> <b>4905 York Road - Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 26 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Hume</b>			

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3953

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b> c. LENGTH OF STAY IN b. <b>104 LONGRIDGE COURT</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>104 LONGRIDGE COURT</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b> d. STREET ADDRESS <b>104 LONGRIDGE COURT</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>IDA VIRGINIA GATES</b>				4. DATE OF DEATH Month Day Year <b>APRIL 14 1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 7, 1873</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>							
13. FATHER'S NAME <b>HENRY SHOUL</b>				14. MOTHER'S MAIDEN NAME <b>ANNA L. DAVIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NO</b>			
17. INFORMANT <b>EDNAG. BRADENBAUGH</b>				Address <b>104 LONGRIDGE CT</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) <b>Coronary Occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>NO</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>BALTIMORE</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) <b>BALTIMORE - MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/17/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE</b>		22d. LOCATION (City, town, or country) (State) <b>BALTIMORE - MD.</b>	
23. FUNERAL DIRECTOR <b>W. M. COOK-TOWSON, INC. TOWSON, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 18 '61</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

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DIVISION OF INVESTIGATION

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DIVISION OF INVESTIGATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03948

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Luzerne Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hazleton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Joseph's Nursing Home</b>		d. STREET ADDRESS <b>110 W. ELM ST.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis T. Gentilini</b>		4. DATE OF DEATH Month Day Year <b>Apr. 13, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 24, 1890</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Austria</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Dr. Joseph Velky 2010 Fernglen Way Catonsville</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia and Congestive Heart Failure</b> 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemiparesis 2 wks ago. Immobile</b> DUE TO (c) <b>Parkinsonism, Severe: Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>4 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1960</b> to <b>April 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>4:14/61</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Emidio Bianco</b>		22b. DATE SIGNED <b>4/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Emidio Bianco M. D.</b>		22d. ADDRESS <b>6322 Windsor Mill Rd Balt #7</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal for burial</b>		23b. DATE THEREOF <b>4/17/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Mt. Carmel</b>		23d. LOCATION (City, town, or county) (State) <b>Hazleton, Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

03342

CENTRAL INTELLIGENCE AGENCY

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3955

Item 230, Film G285 4/24/61 iwk

03949

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> <span style="float: right;">21 Days</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>100 N. Potomac Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JAMES</b> Middle <b>F.</b> Last <b>GODZIK</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>10</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 27, 1897</b>		<b>9. AGE (In years last birthday)</b> <b>64 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>		<b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bartender</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Tavern</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>Henry Godzik</b>								<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha Rachuba</b>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-03-4859</b>				<b>17. INFORMANT</b> <b>Clin. Records. VAH, Balto. Md. Ft. Howard Div.</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>HEPATOMA</b> DUE TO (c) <b>CHRONIC CHOLECYSTITIS WITH CHOLELITHIASIS</b> <b>ARTERIOSCLEROSIS, MARKED</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>RECENT</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)												<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour e.m. <b>19</b> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that</b> (X (this hospital) attended the deceased from <b>March 20, 1961</b> to <b>April 10, 1961</b> , that (X) (we) last saw the deceased alive on <b>April 10, 1961</b> , and that death occurred at <b>1:52 PM</b> , from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i> M.D.												<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>4/11/61</b>				<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M. D.</b>												<b>22d. ADDRESS</b> <b>VAH, BALTO. MD. FT HOWARD DIV.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>4/14/61</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>				<b>23d. LOCATION (City, town or county)</b> (State) <b>Baltimore 28, Maryland</b>							
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Bernard A. Dabrowski, 2818 E. Balto. St. Balto. Md.</b>								<b>25a. REC'D BY REGISTRAR</b> <b>APR 18 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

3956

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03950

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN b <b>20 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b> d. STREET ADDRESS <b>Box 76 Biddle Street</b>	
3. NAME OF DECEASED (Type or print) <b>Kenneth Henry Grabowski</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1933</b>
9. AGE (In years last birthday) <b>28</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Cecil County Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Grabowski</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Javoroski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Rosewood Records; Owings Mills, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute and chronic bilat. bronchopneumonia</b> DUE TO (b) <b>491X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19....., to 19....., that (I) (we) last saw the deceased alive on 19....., and that death occurred at 5 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>P. W. Rieckert</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>P. W. Rieckert</b>		22d. ADDRESS <b>4307 Mainfield Ave, Balt 14</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/17/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Rose</b>		23d. LOCATION (City, town or county) (State) <b>Chesapeake Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pippin Funeral Home</b>		25a. REC'D BY REGISTRAR <b>W. G. Zinsky</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
DATE <b>4/14/1961</b>		APR 20 '61	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03951

3957

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>3001-4</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore # 24,</b> d. STREET ADDRESS <b>3243 Fait Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>M.</b> Last <b>GRAY</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1893.</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Zapf</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Lang.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>----</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edward G. Gray</b> address <b>6818 Conley St. Balto., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.</b> DUE TO <b>Hypertensive Cardiac Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Generalized Atherosclerosis</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Deep vein Thrombosis - Rt. foot</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 19 55</b> to <b>April 6, 19 61</b> that (I) (we) last saw the deceased alive on <b>4/6</b> 19 <b>61</b> , and that death occurred at <b>2:45 P.M.</b> from <b>the</b> causes and on the date stated above.			
22a. SIGNATURE <b>William J. Jankovic M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Mr. S. JAWORSKI M.D.</b>		22d. ADDRESS <b>2711 Eastern Ave. Balto 24</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-10-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>7401 German Hill Rd., Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Gailer</b> ADDRESS <b>901 S. Conkling St. BALTO., 24, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 11 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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BARTON, MD.  
BARTON, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>California</u> b. COUNTY <u>Los Angeles</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>South Gate, California</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glen Arm Road</u>		d. STREET ADDRESS <u>Glen Arm Road 43X-2</u>	
3. NAME OF DECEASED (Type or print) <u>John E. Gray</u>		4. DATE OF DEATH <u>April 23 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16-1888</u>
9. AGE (In years lost birthday) <u>72 7/8</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Appliance Repair</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Electric</u>	
11. BIRTHPLACE (State or foreign country) <u>Jefferson Co. Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Randolph Gray</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Arnold</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>374-05-8478</u>	
17. INFORMANT <u>Mrs Violet Wood</u>		Address <u>Glenarm Road Glen Arm Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4201</u> DUE TO <u>CORONARY INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 23 1961</u> to <u>April 23 1961</u> , that (I) (we) last saw the deceased alive on <u>Apr. 23 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Clifford F. Hudson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CLIFFORD F HUDSON</u>		22d. ADDRESS <u>FORK, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>		23b. DATE THEREOF <u>4-28-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Charity Christian Ch Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield Missouri</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Passan Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 26 '61</u>	
ADDRESS <u>7401 Belair Road</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

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CORRECTION IS IN

OFFICE OF THE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.  
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3953  
CERTIFICATE OF DEATH  
03953

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Essey</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>453 Jenner Rd. Balto. 21</u>		d. STREET ADDRESS <u>453 Jenner Rd. (21)</u>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>E.</u> Last <u>GRIMM</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 9. 1895</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Grimm</u>		14. MOTHER'S MAIDEN NAME <u>Ida Reynolds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>212-07-9541</u>	
17. INFORMANT <u>  </u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC CIRRHOSIS</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>19</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 3, 1961</u> to <u>APRIL 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>APRIL 10, 1961</u> , and that death occurred at <u>4:30 P.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Miceli</u>		22b. DATE SIGNED <u>4/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI, M.D.</u>		22d. ADDRESS <u>1085 TAYLOR AVE, BALTO. 21, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-24-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connolly</u>		25a. REC'D BY REGISTRAR DATE <u>APR 25 '61</u>	
ADDRESS <u>418 Eastern Blvd Balto 21 Md</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	

03023

CENTRODE DE DENTIS

03023

Handwritten notes and signatures, including names like "HARRIS" and "WHITE", and dates like "1972".

Vertical text on the right margin, possibly a page number or reference code.



## CERTIFICATE OF DEATH

Reg. Dist. No.

03954

3960

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>				c. LENGTH OF STAY IN 1b <b>14 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4128 Beachwood Road</b>				d. STREET ADDRESS <b>4128 Beachwood Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>JEANNETTE CATHERINE HAGUE</b>				4. DATE OF DEATH Month Day Year <b>April 4th, 1961</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1898</b>		9. AGE (In years last birthday) <b>62</b> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin A. Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>W.H.Hague same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Basilar artery occlusion</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-15-</b> 19 <b>59</b> , to <b>4-4-</b> 19 <b>61</b> , that I lost saw the deceased olive on <b>4-3-</b> 19 <b>61</b> , and that death occurred at <b>3:20 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7001 Mornington Road</b> DATE SIGNED <b>4/5/61</b>							
ACTUAL SIGNATURE <b>Eugene F. Nevy</b>				M.D. <b>7001 Mornington Road</b>		DATE SIGNED <b>4/5/61</b>	
PHYSICIAN'S NAME (Type) <b>Eugene F. Nevy, M.D.</b>				Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/8/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>				24a. REC'D BY REGISTRAR DATE <b>APR 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

3961

03955

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>LIFETIME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>708 Reisterstown Road</b>				d. STREET ADDRESS <b>1708 Reisterstown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>Agnes</b> Last <b>Hahn</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 25, 1888</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>6</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Henry Roschen</b>				14. MOTHER'S MAIDEN NAME <b>LOUISE AGNES SCHNEIDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>312-03-9388</b>		17. INFORMANT <b>Mr. Irvin H. Hahn, 708 Reisterstown Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174X</b> DUE TO <b>Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatosis</b> DUE TO <b>Carcinoma of the uterus</b> (c) <b>5 years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1960</b> to <b>Apr. 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr. 28, 1961</b> , and that death occurred at <b>10AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Gerald N. Maggid, M.D.</b>				22b. DATE SIGNED <b>4/29/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Gerald N. Maggid, M.D.</b>	
22d. ADDRESS <b>Pikesville, Md.</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>5-3-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town, or county) (State) <b>Pikesville Md</b>	
24. FUNERAL-DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

03052

DEPARTMENT OF HEALTH

1961

Alabama

Alabama

Shelby County, Ala.

Shelby County, Ala.

For Release Only

For Release Only

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Shelby County, Ala.

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Shelby County, Ala.

3962

## CERTIFICATE OF DEATH

Reg. Dist. No. 03958

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bent Nursing Home</u>		d. STREET ADDRESS <u>800 Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>William Edward Hammond</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Masonic Temple</u>	
11. BIRTHPLACE (State or foreign country) <u>West River Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hammond</u>		14. MOTHER'S MAIDEN NAME <u>Annie Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-01-6778</u>	
17. INFORMANT <u>Elois H. Walker</u>		Address <u>2314 Druid Hill Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> <u>15601</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>10 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-25-61</u> to <u>4-27-61</u> , that I last saw the deceased alive on <u>4-26-61</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. Saffer</u> M.D.		DATE SIGNED <u>4-30-61</u>	
PHYSICIAN'S NAME (Type) <u>James E. Saffer</u>		<u>Reisterstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/1/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>	
ADDRESS <u>3035 W. North Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
DATE OF DEATH [Handwritten: Jan 15, 1945]		TIME OF DEATH [Handwritten: 10:30 AM]		PLACE OF DEATH [Handwritten: Home]	
OCCUPATION [Handwritten: Clerk]		CAUSE OF DEATH [Handwritten: Heart Disease]		MANNER OF DEATH [Handwritten: Natural]	
SIGNATURE OF PHYSICIAN [Handwritten: Dr. J. Smith]		SIGNATURE OF REGISTRAR [Handwritten: J. Doe]		SIGNATURE OF WITNESS [Handwritten: J. Doe]	
COUNTY [Handwritten: Baltimore]		CITY [Handwritten: Baltimore]		STATE [Handwritten: Maryland]	



This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.



## CERTIFICATE OF DEATH

Reg. Dist. No.

03957

2963

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>904 Malvern Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles William Hatter</b>				4. DATE OF DEATH Month Day Year <b>April 4, 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1905</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C. P. A.</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Elmer D. Hatter</b>				14. MOTHER'S MAIDEN NAME <b>Alice Virginia Metcalfe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-36-6394</b>		INFORMANT Address <b>Mildred Flichman Hatter-904 Malvern Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Dilatation Heart.</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma Pancreas.</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>4 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 21, 1960</b> to <b>April 4, 1961</b> , that I last saw the deceased alive on <b>April 3, 1961</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Carl F. Benson, M.D.</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>5111 York Rd Baltimore, Maryland April 4, 1961</b>			
PHYSICIAN'S NAME (Type) <b>Carl F. Benson, M.D.</b>				<b>B. H. 12 md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/7/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ellsworth Armacost-4600 Liberty Hghts. Ave.</b>				24a. REC'D BY REGISTRAR <b>APR 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03957

CENTRAL OFFICE OF DEATH

03957



RECEIVED  
JAN 12 1965  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
MEMORANDUM  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 03958

3964

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>				d. STREET ADDRESS <b>Glenarm Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sister Mary Hugh Hauser</b> Middle <b>Hauser</b> Last <b>Hauser</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 11, 1879</b>		9. AGE (In years lost birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min. <b>81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS</b>		11. BIRTHPLACE (State or foreign country) <b>Jersey City, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August Hauser</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Fried</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sister M. Peter Fourier</b> Address <b>Notch Cliff, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of lung</b> DUE TO <b>153.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of bowel</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 53</b> , to <b>April 61</b> , that I last saw the deceased alive on <b>April 11</b> , 19 <b>61</b> , and that death occurred at <b>6 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road Towson 4, Md.</b> DATE SIGNED <b>4/11/61</b>							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-13-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NR. TOWSON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Jailer</i>				ADDRESS <b>901 S. CONKLING ST. BALTO., 24, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 13 '61</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hauser</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

3965

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03959

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2117 Middleborough Rd.</u>				d. STREET ADDRESS <u>2117 Middleborough Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN RICHMOND HAYES</u>				4. DATE OF DEATH Month Day Year <u>April 22. 19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Stewart MacKay</u>				14. MOTHER'S MAIDEN NAME <u>Martha ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>172-10-9892A</u>		17. INFORMANT Address <u>Richmond Kershaw Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Myocardial insufficiency</u> DUE TO (c) <u>Gen. Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>422.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Myeloma</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack E. Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack E. Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdinski</u>				ADDRESS <u>1407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur P. K...</u>			

DATE SIGNED

4-22-61





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

3966

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03960

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN 1b <b>11 mo. 13 da.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4503 Gretna St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Georgia Sive Hecht</b>		4. DATE OF DEATH Month Day Year <b>4 13 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/1904</b>
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Millinery</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Chapman Sive</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Dyson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>011-14-7899</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far Advanced Pulmonary Tuberculosis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ 002X		INTERVAL BETWEEN ONSET AND DEATH <b>18 mo.</b> <b>18 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pyelonephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/29, 1960</b> to <b>4/13, 1961</b> , that (I) (we) last saw the deceased alive on <b>4/13, 1961</b> , and that death occurred at <b>8:25 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b> M.D.		22b. DATE SIGNED <b>4/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/17/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>		DATE <b>PR 17 '61</b>	

03560

CERTIFICATE OF DEATH

5000

1

State of Maryland, County of Baltimore, City of Baltimore, I, the undersigned, being a duly qualified and sworn physician, do hereby certify that on the 1st day of January, 1900, at the City of Baltimore, Maryland, I attended the body of one [Name], who died at the residence of the deceased, and that the cause of death was [Cause of Death], and that the deceased was [Age] years of age, and that the deceased was [Sex] sex, and that the deceased was [Race] race, and that the deceased was [Religion] religion, and that the deceased was [Marital Status] marital status, and that the deceased was [Occupation] occupation, and that the deceased was [Education] education, and that the deceased was [Social Status] social status, and that the deceased was [Other Information] other information.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3967

## CERTIFICATE OF DEATH

03961

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>715 Woodsdale Ave.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS <b>Catonsville 28</b>		
3. NAME OF DECEASED (Type or print) First <b>T.</b> Middle <b>Bernard</b> Last <b>Heilmann</b>			4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1890</b>	9. AGE (In years last birthday) yrs. <b>71</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy-Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>George Heilmann</b>			
14. MOTHER'S MAIDEN NAME <b>Matter</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes W.W.1</b>			
16. SOCIAL SECURITY NO. <b>216-03-6578</b>		17. INFORMANT <b>Alice M. Heilmann-715 Woodsdale Ave.-28-</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized Arterio Sclerosis</b> (c) <b>57 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (the hospital) attended the deceased from <b>June 1930</b> to <b>April 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 17, 1961</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Wetherbee Fort</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wetherbee Fort</b>		22d. ADDRESS <b>6500th Ave - Catonsville 28. Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4--20--1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Cemetery</b>	23d. LOCATION (City, town or county) <b>Baltimore</b>	(State) <b>Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall &amp; Son</b>		ADDRESS <b>301 Frederick Ave; 28</b>		25a. REC'D BY REGISTRAR <b>APR 20 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

03221

(M)

(I)

Caravan, Beckman  
Jen, 1917 (1918)

Wetherbee, J. W.  
1917-1918  
Jen, 1917 (1918)

Wetherbee, J. W.  
1917-1918  
Jen, 1917 (1918)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3968 CERTIFICATE OF DEATH 03962											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore 13</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 13</b> d. STREET ADDRESS <b>1809 N. Durham Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>PAUL J. HERFURTH</b>						4. DATE OF DEATH <b>April 22 19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 20, 1897</b>		9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Distillery Company</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Curtis Bay, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Karl Herfurth</b>						14. MOTHER'S MAIDEN NAME <b>Josephine Zaruka</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WW 11</b>						16. SOCIAL SECURITY NO. <b>3900 Loch Raven Blvd. Balto 18, Md. FT. HOWARD</b>					
17. INFORMANT <b>Clinical Records</b>						18. ADDRESS <b>VA Hospital DIV.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> (c) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Hypertensive Cardiovascular Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 19 1961</b> to <b>April 22 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 22 1961</b> , and that death occurred at <b>1:28 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>M. Lawrence Rubin, M.D.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>4/22/61</b>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>M. LAWRENCE RUBIN, M.D.</b>						22d. ADDRESS <b>VAH, 3900 Loch Raven Blvd. Baltimore 18, Md. FORT HOWARD DIVISION</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4-26-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leo Cook &amp; Son</b>						25a. REC'D BY REGISTRAR <b>1701 N. Patterson Pk Ave. Balto, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		DATE <b>APR 24 '61</b>	

03008

03008

(M)

Mr. Jones

Mr. Jones

Washington 13

2 days

2 days

1000 V. Hudson Street

Veterans Administration Hospital

April 22

April 22

Washington

U. S.

April 22

March 20, 1907

April 22

April 22

Washington Company, Office Bldg., Maryland

Washington

Washington State

Washington State

Clinical Records, VA Hospital, 1000 V. Hudson Street, Washington

Washington State

CENTRAL WASHINGTON

THE STATE OF WASHINGTON

Representative Washington State

April 13, 1907

April 22

Washington State

Washington State

Washington State

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Washington State

Washington State



## CERTIFICATE OF DEATH

Reg. Dist. No. 03963

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b <u>254rs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 Cypress Ct</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>101 Cypress Ct</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Novella</u> <u>Virginia</u> <u>Hill</u> First Middle Last		4. DATE OF DEATH <u>April</u> <u>7</u> <u>1961</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 2, 1909</u> 9. AGE (In years last birthday) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>	
11. BIRTHPLACE (State or foreign country) <u>Holland, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Willie Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Georgie Sumblor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-22-374</u>	
17. INFORMANT <u>Hortense Henry</u> Address <u>108 N. Benton St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> <u>1946</u> to <u>April 4, 1961</u> , that I last saw the deceased alive on <u>April 4, 1961</u> , and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u> M.D.		ADDRESS (Street, city or town, state) <u>1400 Gt Avenue</u> DATE SIGNED <u>4-4-61</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-9-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Holland, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Avenue, Balto., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03964

3970

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>X</b> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Owen Hilton</b>		4. DATE OF DEATH <b>April 17 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2--24--1902</b>
9. AGE (In years and birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Transit Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Thomas O. Hilton</b>	
14. MOTHER'S MAIDEN NAME <b>Rachel Ewald</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>213-10-2513</b>		17. INFORMANT <b>Mrs Myrtle H. Hilton 43 Wade Ave-28- Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>GEO. S. M. KIEFFER, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>April 17 1961</b>	
EXAMINER'S NAME (Type) <b>GEO. S. M. KIEFFER, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>1610 Leads on</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-20--1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>301 Frederick Road 28</b>		24a. REC'D BY REGISTRAR <b>DATE APR 20 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03965

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN 1b <b>4 YEARS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE CITY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b> d. STREET ADDRESS <b>3609 DUDLEY AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARROLL</b> Middle <b>PETER</b> Last <b>HOBBBS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 19 1901</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>59</b> Min.	11. IF UNDER 24 HRS. Months <b>5</b> Days <b>19</b> Hours <b>59</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKERY SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BREAD AND PASTRY</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SAMUEL HOBBBS</b>		14. MOTHER'S MAIDEN NAME <b>MARY GRIMES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-10-6430</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO (b) <b>9 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) <b>9 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/20</b> 19 <b>56</b> to <b>4-7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4-7</b> 19 <b>61</b> , and that death occurred at <b>5:15</b> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>REMOVAL</b>	<b>4-11-61</b>	<b>ST. MARY'S Cem.</b>	<b>BALTO, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>L.J. Ruck, Inc. - 5305 Harford Rd</b> <b>per. L. G. Miller</b>		25a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



CERTIFICATE OF DEATH

1934

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03966

3972

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eatonville</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House in Pine 16 Rustling Ave</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> <span style="float: right;">b. COUNTY <u>3V01-4</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>636 Wildwood</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lena E.</u> Middle <u>V</u> Last <u>Hook</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>7</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan. 8, 1898</u>
<b>9. AGE</b> (In years last birthday) <u>63</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>1</u>	
<b>11. IF UNDER 24 HRS.</b> Hours <u>1</u> Min. <u>0</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto. Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Wm. A. Beery</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Eugenia Korn</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> Address <u>Sebastian H. Hook</u>	
<b>17. INFORMANT</b> Address <u>Sebastian H. Hook</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of left breast</u> (c) <u>4/1/1960</u> DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour e.m. <u>19</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Jan 11, 1960</u> to <u>Apr 7, 1961</u> that (I) (we) last saw the deceased alive on <u>Apr 7, 1961</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>George A. Knipp</u> M.D.		<b>22b. DATE SIGNED</b> <u>Apr 8 1960</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>George A. Knipp</u>		<b>22d. ADDRESS</b> <u>4116 Edmondson Ave</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/10/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lorraine Pk.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Worrlawn T. Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke T.H.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 10 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kane</u>		Address <u>4101 Edmondson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
3973 Item 9 Film G264 4/13/61 1wk													
03967													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>28 hrs 15 min.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3137 Eastern Avenue</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BUSTER T. HOWARD</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 18, 1916</b>		9. AGE (In years last birthday) <b>44 1/2</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House Painter</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Lexington, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Howard</b>				14. MOTHER'S MAIDEN NAME <b>Susan (Maiden Name Unknown)</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW PL 28</b>				16. SOCIAL SECURITY NO. <b>524-01-2630</b>				17. INFORMANT <b>Clin. Records. VAH, Balto. Md. Ft. Howard Div.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE RIGHT RECENT</b> DUE TO (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>BRONCHOPNEUMONIA, RECENT</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c), STATING THE UNDERLYING CAUSE TEST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>April 4 1961, April 5 1961, that (4) (we) last saw the deceased alive on April 5 1961, and that death occurred at 3:30 PM from the causes and on the date stated above.</b>													
21. I certify that (4) (this hospital) attended the deceased from <b>April 4 1961</b> to <b>April 5 1961</b> , that (4) (we) last saw the deceased alive on <b>April 5 1961</b> , and that death occurred at <b>3:30 PM</b> from the causes and on the date stated above.				22a. SIGNATURE <b>Thomas F. Crahan, M.D.</b>				22b. DATE SIGNED <b>4/6/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>				22d. ADDRESS <b>VAH, BALTIMORE, MD. FT HOWARD DIVISION</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-10-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>				23d. LOCATION (City, town or county) (State) <b>BALTIMORE 28, MARYLAND</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook Blight, Inc. 6009 Harford Rd. Balto. Md.</b>				25a. REC'D BY REGISTRAR <b>APR 10 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3974

Items 1 & 2 Film G286 5/4/61 iwk

## CERTIFICATE OF DEATH

03968

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>Anne Arundel County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> c. LENGTH OF STAY IN TB <b>Arbutus</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1713 Wilson Avenue, A/A/Co</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> d. STREET ADDRESS <b>3116 Hilltop Av.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Fannie J. Howard</b>		4. DATE OF DEATH <b>4/25/61</b> Last Month Day Year <b>19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/30/1878</b>
9. AGE (In years last birthday) <b>83</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Doffmyer</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Edna Hill, 3116 Hilltop Av.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO (b) <b>Advances of Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Parkinson's Disease due to Cerebral Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b> <b>7 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <b>May 14, 1955</b> to <b>April 25, 1961</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>April 22, 1961</b> , and that death occurred at <b>4:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>C. Arthur Rossberg M.D.</b>		22b. DATE SIGNED <b>4/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. ARTHUR ROSSBERG MD</b>		22d. ADDRESS <b>2436 WASHINGTON Blvd. Balto. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/28/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d. LOCATION (City, town or county) (State) <b>Anne Arundel Co.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd. (14)</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

03868

3075

THIRTY

Yankee J. 1900

John D. 1900

1900

Anna Anderson Co.

London, E.

May 1, 1900

See also right in 0000 (1900)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

3975

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03969

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2529 Canterbury Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Augusta</u> Middle <u>Jobkins</u> Last <u>Jobkins</u>		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Templin</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia, Acute, Severe</u> DUE TO (b) <u>Coma, Deep,</u> DUE TO (c) <u>Arteriosclerosis Generalized (Especially Cerebral)</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 Hrs</u> <u>2 1/2 Hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis, severe, esp. left hip; ii) Decubiti, severe, multiple</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1/10/</u> , 19 <u>61</u> , to <u>4/23</u> , 19 <u>61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4/23</u> , 19 <u>61</u> , and that death occurred at <u>5</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward L. Molz</u>		22b. DATE SIGNED <u>24 April 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward L. J. Molz, M.D.</u>		22d. ADDRESS <u>7425 Harford Rd. Balto. 14 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-27-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>APR 26 '61</u>	
ADDRESS <u>5305 Harford Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>	

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Leonard J. Moore 2305 Harvard Rd.  
4-27-1901  
Edward J. Moore, M.D. 1025 Harvard Rd. Boston, Mass.  
24 April 1901  
1/10 of 4/22  
if it is found that the left half of the brain is diseased, the right half of the brain is also diseased.  
Arturoscleosis (cerebral) (Cerebral) 22.2 cm.  
Gross, large.  
Acute, severe, diffuse, bilateral, symmetrical, and extensive, involving the entire brain, and the spinal cord, and the meninges, and the blood vessels, and the lymphatic system, and the nervous system, and the entire body.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

3976

03970

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>83 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <input checked="" type="checkbox"/> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1727 Madison Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ARTHUR</b> Middle <b>R.</b> Last <b>JOHNSON</b>			<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>11</b> Year <b>19 61</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>January 1896</b>		<b>9. AGE (In years last birthday)</b> <b>65</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>65</b> Days <b>65</b>			
<b>11. IF UNDER 24 HRS.</b> Hours <b>65</b> Min. <b>65</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Harry Johnson</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Fanny Grant</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>WW I 218-07-5865</b>			
<b>17. INFORMANT</b> <b>Clin. Records, VAH, Balto. Md. Ft. Howard Div.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA RECENT</b> (b) <b>CHRONIC PYELONEPHRITIS</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <b>January 18, 1961</b>		<b>20g. (County)</b> <b>April 11, 1961</b>		<b>20h. (State)</b> <b>9:05PM</b>			
<b>21. I certify that</b> <b>TH</b> (this hospital) attended the deceased from <b>January 18, 1961</b> to <b>April 11, 1961</b> , that <b>TH</b> (we) last saw the deceased alive on <b>April 11, 1961</b> , and that death occurred at <b>9:05PM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i>		<b>22b. DATE SIGNED</b> <b>4/12/61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M. D.</b>			
<b>22d. ADDRESS</b> <b>VAH, BALTIMORE, MD. - FT HOWARD DIVISION</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>4-17-61</b>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>BALTIMORE NATIONAL</b>		<b>23d. LOCATION (City, town or county)</b> <b>BALTIMORE 28, MARYLAND</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b>			
<b>25a. REC'D BY REGISTRAR</b> <b>DATE APR 14 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>		<b>25c. WILLIAM A. JACKSON FUNERAL HOME, 3814 BONNER RD. BALTIMORE, MD.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01251

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Item 14 Film G285 4/27/61 iwk

03971

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2617 Canterbury Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bertha M. Johnson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19th</u> Year <u>1961</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1900</u>	9. AGE (in years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife &amp; saleslady Dept. store</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Bromwell</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>219012470</u>				17. INFORMANT <u>Ellsworth D. Johnson</u> Address <u>same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Obesity, moderately severe</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>30 July</u> , 19 <u>53</u> , to <u>19 April</u> , 19 <u>61</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>8 April</u> , 19 <u>61</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward L. J. Molz, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edward L. J. Molz, M.D.</u>				22d. ADDRESS <u>7425 Harford Rd. Balto. 14 Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-22-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				25a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



1900

185







100-100000

DEPARTMENT OF HEALTH  
STATE OF NEW YORK

CERTIFICATE OF DEATH

100-100000

Blank certificate form with horizontal lines for text entry.



## CERTIFICATE OF DEATH

03973

3979

Items 13 &amp; 14, telephone call -Ulrich Funeral Home 4/18/61.cac

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MD.

b. COUNTY

BALTO.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

DUNDALK

c. LENGTH OF STAY IN 1b

LIFE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X DUNDALK

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

3159 BAYBRIAR RD.

d. STREET ADDRESS

13159 BAYBRIAR RD.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

## 3. NAME OF DECEASED (Type or print)

First LOUISE

Middle

Last

KANE

## 4. DATE OF DEATH

Month

APRIL

Day

17

Year

1961

## 5. SEX

F

## 6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

## 8. DATE OF BIRTH

JULY 22, 1976

## 9. AGE (In years lost birthday) yrs.

84

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

AT HOME

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

— NEILL, William Henry

## 14. MOTHER'S MAIDEN NAME

— ARNETT, Jane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

—

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

## INFORMANT

Address

CHARLES H. RANDALL 3159 BAYBRIAR RD.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Coronary Occlusion

Hypertension

## INTERVAL BETWEEN ONSET AND DEATH

1 day-

2 yrs-

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from March 1959, to April 17/61, that I last saw the deceased alive on April 17, 1961, and that death occurred at 4 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE

J. H. Thomas

M.D.

ADDRESS (Street, city or town, state)

107 N. Main St.

DATE SIGNED

4/17/61

PHYSICIAN'S NAME (Type)

J. H. Thomas

BALTO 22

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

## 22b. DATE THEREOF

4-20-61

## 22c. NAME OF CEMETERY OR CREMATORY

OAK LAWN

## 22d. LOCATION (City, town, or county)

COLGATE,

(State)

MD.

## 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

ULRICH FUNERAL HOME, DUNDALK, MD.

## 24a. REC'D BY REGISTRAR

DATE APR 18, '61

## 24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

1930

STATE OF NEW YORK

1930

(M)

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

3980

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03974

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>				c. LENGTH OF STAY IN 1b <b>1yr 3 mos +</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Rose</b> Last <b>Karn</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/3/1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewing</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
13. FATHER'S NAME <b>Unknown George Karn</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Mary Velte</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>RECORDS: Spring Grove State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/25</b> <b>1961</b> , to <b>4/28</b> <b>1961</b> , that (I) (we) lost the deceased alive on <b>4/28</b> <b>1961</b> , and that death occurred at <b>9:50</b> <b>A.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Loretta Hsu</b>				22b. DATE SIGNED <b>4/28/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Loretta Hsu M.D.</b>				22d. ADDRESS <b>Spring Grove State Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>5-1-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN PK Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Balto 29 MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCurly Funeral Homes 130 E York Ave</b>				25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>			
ADDRESS <b>614 D</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

MEDICAL CERTIFICATION

03034

CERTIFICATE OF DEATH

1928

X

John H. Lee

RECEIVED  
JAN 10 1928  
U.S. DEPT. OF HEALTH  
BUREAU OF VITAL STATISTICS



1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nur. Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>T.</u> Last <u>Keithley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1820</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Jonathan. Keithley</u>		14. MOTHER'S MAIDEN NAME <u>Anna E. Cullum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-32-9106</u>	
INFORMANT Address <u>Chas. S. Keithley Box 205 White Marsh, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. <u>Generalized arteriosclerosis &amp; uremia</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Hypertrophy of prostate.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>Samuel Stern</u> attended the deceased from <u>3/4</u> , 19 <u>61</u> , to <u>4/15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>61</u> , and that death occurred at <u>2:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Stern</u> M.D.		ADDRESS (Street, city or town, state) <u>Sam Ridge Rd. Baltim-on 6.</u> DATE SIGNED <u>4/21/61</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL STERN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessahy Funeral Home</u> ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

CERTIFICATE OF DEATH

1

1

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

03976

Reg. Dist. No. ....

3982

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the funeral director should detach for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>			
CITY OR TOWN <b>Rural Stevenson</b>		LENGTH OF STAY (in this place) <b>Lifetime</b>		CITY OR TOWN <b>Stevenson, Md.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <b>Keller Road</b>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Harry Hamilton Keller</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>April 21, 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 12, 1896</b>	9. AGE last birthday <b>65</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Son Harry H. Keller</b>		11. BIRTHPLACE (State or foreign country) <b>Stevenson, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jackson E. Keller</b>				14. MOTHER'S MAIDEN NAME <b>Ida Merrick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>216-05-9057</b>		17. INFORMANT & ADDRESS <b>Stevenson, Md. Mrs. Mary Ethel Keller, Keller Rd.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
177X IMMEDIATE CAUSE (A) <b>Carcinoma portale</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>metastasis to bone etc.</b>						<b>2 years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Apr 28</b> , 19 <b>58</b> , to <b>Apr 21</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Apr 21</b> , 19 <b>61</b> , and that death occurred at <b>9 P</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Patricia F. Williams</b>		ADDRESS (Street, city, town, state) <b>Linn Rd. Owings Mills, Md.</b>		DATE SIGNED <b>May 1, 1961</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>April 24, 1961</b>		NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Charles L. Kneass</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Howell</b>		ADDRESS <b>2nd St. Pikesville, Md.</b>	
DATE <b>APR 25 '61</b>							



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3983

## CERTIFICATE OF DEATH

03977

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN lb <b>41 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (18)</b> g. STREET ADDRESS <b>545 East 23rd Street</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>JAMES W. KELLY</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>27</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b>			
<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 11, 1930</b>			
<b>9. AGE</b> (In years last birthday) <b>31 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Timekeeper</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>John H. Kelly</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Bessie Byrne</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>Korean</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-26-5905</b>		<b>17. INFORMANT</b> <b>Clinical Records, VAH, Baltimore 18, Maryland</b> <b>FORT HOWARD DIVISION</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> (b) <b>ASPIRATION</b> (c) <b>ULCERATIVE COLITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>FEW HOURS</b>  <b>5 MONTHS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (a) (this hospital) attended the deceased from March 17, 1961 to April 27, 1961 that (b) (we) last saw the deceased alive on April 27, 1961, and that death occurred at p.m., from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Thomas F. Crahan</i>		<b>22b. DATE SIGNED</b> <b>4/28/61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M.D.</b>			
<b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5-1-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>New Cathedral Cemetery</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Baltimore, Maryland</b>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 1 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Hume</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

Leopold J. Huchsoy, Harry M. Latta, Jr.,

New Commercial Company

THOMAS A. GRAHAM, M.D.

VAN BUREN, JR., M.D., 17. HOWARD DIVISION

April 27

March 17

ALCOHOLIC COGNAC

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BRANDY

WINE

WINE, BRANDY, WHISKY, V.O. S. W. 1865

John A. Kelly

Wine

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1883

1883



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03978

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Liberty Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution; Residence before admission) e. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Balto.</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills</u> d. STREET ADDRESS <u>Deer Park Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Patrick Joseph Kennedy</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>7</u> Year <u>19 61</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>March 14, 1893</u>		<b>9. AGE</b> (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Sun Cab Co.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Thomas Kennedy</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-18-9050</u>		<b>17. INFORMANT</b> <u>Mrs. Gladys Johnson Owings Mills, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Chr. Valvular Heart Disease</u> DUE TO (c) <u>Bronchial Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>30 min</u> <u>?</u> <u>?</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e):							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Apr. 6, 1961</u> , to <u>Apr. 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>Apr. 6, 1961</u> , and that death occurred at <u>  </u> M., from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>M. E. Martue</u>			<b>22b. DATE SIGNED</b> M.D. <u>  </u>		<b>22c. ADDRESS</b> <u>Randallstown Md</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>April 10, 61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Granite Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Granite</u>		<b>(State)</b> <u>Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. F. Eline &amp; Sons</u>			<b>ADDRESS</b> <u>Reisterstown, Md.</u>				
<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 12 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

08978

(M)

(1)

George Washington  
The President of the United States  
Executive Order

1797  
George Washington  
The President of the United States  
Executive Order

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3985

## CERTIFICATE OF DEATH

Reg. Dist. No. 03979

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3016 Taylor Ave</u>		d. STREET ADDRESS <u>3016 Taylor Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel</u> <u>May</u> <u>Kirby</u>		4. DATE OF DEATH Month Day Year <u>Apr</u> <u>9</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1878</u> 82 yrs.
9. AGE (In years last birthday) <u>82</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ontario, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hiram Jones</u>		14. MOTHER'S MAIDEN NAME <u>Ida Medora Hannan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss Miriam T. Kirby</u>		Address <u>3016 Taylor Ave. #14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic CVD.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 yr. +</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 1957, to <u>4/9</u> , 1961, that I last saw the deceased alive on <u>4/6/61</u> , 19 <u>61</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8100 Hayford Rd -</u> DATE SIGNED <u>4/10/61</u> ACTUAL SIGNATURE <u>H. A. Grott</u> M.D. PHYSICIAN'S NAME (Type) <u>H. A. GROTT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodmere Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Detroit Michigan</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Townson Inc.</u>		ADDRESS <u>1050 York Rd. #4</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 12 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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(M)  
3986  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03980

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b> c. LENGTH OF STAY IN 1b <b>17 years plus</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Koch</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1879</b>
9. AGE (In years, months, days) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 10</b> , 19 <b>61</b> , to <b>April 12</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>April 12</b> , 19 <b>61</b> , and that death occurred at <b>12:58 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachsler</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachsler M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4 - 17 - 61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc. 1217 St. Paul St., Baltimore 2, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Travis</b>			

03060

CERTIFICATE OF DEATH

1906

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CHIEF CLERK

MADE IN

Baltimore

1906



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
3987					03981									
Item 23b, Film G286 5/12/61 iwk														
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>60 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>VET. ADM. HOSP.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>505 ACADEMY ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>PETER J KURAPKA</b>			4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 61</b>											
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 17, 1912</b>		9. AGE (In years last birthday) <b>49</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Quality Control</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Plymouth Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
13. FATHER'S NAME <b>Peter KURAPKA</b>					14. MOTHER'S MAIDEN NAME <b>Anna SUYETA</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>8-30-28/8-29-31</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>184-12-1737</b>					17. INFORMANT <b>CLIN REC VAH BALTIMORE MD-FT HOWARD DIVISION</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED PERITONITIS</b> DUE TO <b>157X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>PERFORATION OF STOMACH AND BOWEL</b> DUE TO (c) <b>CARCINOMA OF PANCREAS</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b> <b>1 Day</b> <b>Unknown</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BRONCHOPNEUMONIA</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>March 1, 1961</b> , to <b>April 30, 1961</b> that <b>X</b> (we) last saw the deceased alive on <b>April 30, 1961</b> , and that death occurred at <b>2:00</b> A.M. from the causes and on the date stated above.														
22a. SIGNATURE <b>Donald W. Stewart</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4-30-61</b>							
22c. PHYSICIAN'S NAME (Type) <b>Donald W Stewart M.D.</b>					22d. ADDRESS <b>VAH Balto 18 Md - Ft Howard Division</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>May 3, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick &amp; Wade Ave MacNabb Funeral Home Catonsville Maryland</b>					25a. REC'D BY REGISTRAR <b>MAY 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>							

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3988

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03982

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 2/57

FOR STATE  
HEALTH DEPT.

(M)

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>9 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Fort Howard</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 14 Old North Point Rd.</b>				d. STREET ADDRESS <b>114 Old North Point Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Labie</b> Last <b>Labie</b>				4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1896</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Sgt. U. S. Army</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Labie</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kuban</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Army Ret.</b>		16. SOCIAL SECURITY NO. <b>213-28-7717</b>		17. INFORMANT Address <b>Mrs. Emma Mlynarski 53 Ontario St. Pitt Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b> <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Obesity</b> (c) <b>None</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>M. B. Davis</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b> DATE SIGNED <b>4/21/61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-24-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA 7922 Wise Ave. 22, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

pp 2

13082

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
DEPT.

(1)

QUALITY OF DEATH

NAME OF DECEASED		DATE OF DEATH	
RESIDENCE		CITY OR TOWNSHIP	
COUNTY		STATE	
AGE		SEX	
DATE OF BIRTH		PLACE OF BIRTH	
MARRIED		SINGLE	
OCCUPATION		EDUCATION	
RELIGION		RACE	
MANNER OF DEATH		CAUSE OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
SMOKING HISTORY		ALCOHOLIC HISTORY	
DRUG HISTORY		MENTAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
X-RAY EXAMINATION		AUTOPSY	
SIGNATURE OF EXAMINER		DATE OF SIGNATURE	
OFFICIAL SEAL		OFFICIAL TITLE	

## CERTIFICATE OF DEATH

Reg. Dist. No.

03983

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>6 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1732 Burnham Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE MARIE Larson</b>		4. DATE OF DEATH Month Day Year <b>April 8 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1925</b>
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Christopher</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Kehoe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>J.B. Larson</b>	
17. INFORMANT <b>same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of Uterus with metastasis generalized</b> 2yrs. 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hyperthroid</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 7, 1961</b> to <b>April 8, 1961</b> , that I last saw the deceased alive on <b>April 7, 1961</b> , and that death occurred at <b>8:30 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Jack C. Collins</i>		ADDRESS (Street, city or town, state) <b>2 Kinship Rd.</b>	
PHYSICIAN'S NAME (Type) <b>Jack C. Collins M.D.</b>		DATE SIGNED <b>April 22 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Kingston, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR <b>April 10 1961</b>	
24b. REGISTRAR'S SIGNATURE <i>Carlton E. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



and time:

• CONFIDENTIAL

U. S. and Co. • Wash.





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REAR OF SEAT  
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3991

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03985

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		c. LENGTH OF STAY IN 1b <u>10yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hess Rd.</u>				d. STREET ADDRESS <u>Hess Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jesse James Leedy</u>				4. DATE OF DEATH Month Day Year <u>APR. 8 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 29 1906</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Wytheville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence P. Leedy</u>				14. MOTHER'S MAIDEN NAME <u>Florence Cline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-0447</u>		17. INFORMANT Address <u>Mrs. Laura Leedy, Monkton, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed skull caused by shot</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>gun blast</u> (c) DUE TO (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pat barrel shotgun in mouth and pulled trigger</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>4/5 1961</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>MONKTON, BALTO. MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 8, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Phoenix, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jacob Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3992  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03986

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>11 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH YOUNG LEIDNER</b>		4. DATE OF DEATH Month Day Year <b>APRIL 18 1961</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-1870</b>
9. AGE (In years lost birthday) yrs. <b>90</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>90</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCOTLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>SCOTLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM PATTERSON STRATTON</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH YOUNG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Vascular Disease</b> DUE TO (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-2</b> 19 <b>50</b> , to <b>4-18</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4-17</b> 19 <b>61</b> , and that death occurred at <b>5:55 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>4/18/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 21, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>		ADDRESS <b>1217 St. Paul Street</b>	
25a. REC'D BY REGISTRAR <b>APR 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

Baltimore County, Md.

Notary Public

April 21, 1901

Filed

1217 N. 1st Street

Wilmington, Del.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3993

## CERTIFICATE OF DEATH

Reg. Dist. No. 03987

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg 06X2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood Sanatorium Towson 4, Maryland</b>				d. STREET ADDRESS <b>Box 307</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>L</b> Last <b>LEISTER</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 18 1903</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WORKED ON FARM</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CARROLL CO. MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>WENTON LEISTER</b>				14. MOTHER'S MAIDEN NAME <b>SARA A. RECHSLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-36-4120</b>		17. INFORMANT Address <b>Miss Edna V. Leister, Finksburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF MESENTERIC CYST</b> <b>158X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>3-15</b> , 19 <b>61</b> , to <b>4-2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>4-1</b> , 19 <b>61</b> , and that death occurred at <b>6:20</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Milton B. Kress</b> M.D. PHYSICIAN'S NAME (Type) <b>Milton B. Kress</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/5/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Leister Cemetery Rural, Westminster, Md.</b>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Meyer, Jr., Westminster, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-03

10-03

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF NEAREST RELATIVE		17. SIGNATURE OF CLERK		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF CORONER		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
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43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
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49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
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73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
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79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
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94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

WILLIAM BOND

10-03

10-03

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 3994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03988

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FOR STATE  
HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Jarrettsville Pike, Phoenix, Md</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b> d. STREET ADDRESS <b>Jarrettsville Pike, Phoenix</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert Hen ry Lins</b>		4. DATE OF DEATH Month <b>4</b> Day <b>20</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-1877</b>
9. AGE (in years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veterinarian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Doctor</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Christian Lins</b>		14. MOTHER'S MAIDEN NAME <b>Margareta Daneker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Box 32</b>	
17. INFORMANT <b>Mrs. W. Leroy Conklin</b>		Address <b>Phoenix, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO (b) <b>Myocardial Regeneration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Sudden</b> <b>3 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles O'Donnell</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/20/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-22-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Jacksonville Reform</b>		22d. LOCATION (City, town, or country) (State) <b>Phoenix Maryland</b>	
23. FUNERAL DIRECTOR <b>Brooks Funeral Service Towson 4, Md</b>		24a. REC'D BY REGISTRAR <b>APR 24 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3995

03989

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN TB <b>4 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4102 Audrey Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STANLEY A. LISIEWSKI</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>20TH</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/7/15</b>
9. AGE (in years last birthday) <b>46</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alexander Lisiewski</b>	
14. MOTHER'S MAIDEN NAME <b>Rose MN: Nakovicz</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>217-09-0544</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE STOMACH</b> DUE TO (b) <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>April 16, 1961 to April 20, 1961</b> <b>5:15 PM</b> 21. I certify that (this hospital) attended the deceased from April 16, 1961 to April 20, 1961 that (I/we) last saw the deceased alive on April 20, 1961, and that death occurred at 5:15 PM from the causes and on the date stated above. 22a. SIGNATURE <i>George C. McElfatrick</i> M.D. 22b. DATE SIGNED <b>4/20/61</b> 22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. McELFATRICK, M.D.</b> 22d. ADDRESS <b>VAH, BALTO. MD. FORT HOWARD DIVISION</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 24, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b>		25a. REC'D BY REGISTRAR <b>APR 26 '61</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Finas</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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[illegible]

George L. Brown, 1901 Governor, 1877-1880.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP A15 (4)  
15M 9/59

3996

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03990

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>3 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>XXXX</b> Middle <b>Dora</b> Last <b>May Lloyd</b>		4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-13-1874</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>25</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Bremker</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Helen A. Sines</b>		Address <b>Westminster Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio Vascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>4/25</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19 59</b> to <b>4/25</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/25</b> 19 <b>61</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. M. France</b>		22b. DATE SIGNED <b>4/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>		22d. ADDRESS <b>Parkton, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>4-28-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Blackrock Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Butler Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service Towson 4, Md</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinas</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03991

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Samuel Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Andrew</b> Last <b>Lloyd</b>		4. DATE OF DEATH Month <b>4</b> Day <b>8</b> Year <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-1870</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		12. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Silas Paul Lloyd</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Governor Lloyd</b>		Address <b>Owings Mills Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocarditis Decompensata</b> DUE TO (b) <b>virus infection</b> DUE TO (c) <b>R pneumoniae</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 yrs</b> <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>1</b> p. m. <b>30</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-1-39</b> to <b>4-8-61</b> , that (I) (we) last saw the deceased alive on <b>4-7-61</b> , and that death occurred on <b>4-8-61</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. Saffell</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James E. Saffell</b>		22d. ADDRESS <b>Reisterstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-11-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Falls Road Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Butler Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b>		25a. REC'D BY REGISTRAR <b>APR 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

03031

TEST CASE OR DEATH

2001

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3998 Items 8 & 9 film G285 4/27/61 ink 03992											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1718 Hillyard Road</u>						d. STREET ADDRESS <u>1718 Hillyard Road</u>					
3. NAME OF DECEASED (Type or print) First <u>Abner</u> Middle <u>Lee</u> Last <u>Lockett</u>						4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>19 61</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-23-1873</u> 1876 <u>8483</u> yrs.		9. AGE (If years last birthday) <u>84</u> yrs.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rubin Wintrey Lockett</u>						14. MOTHER'S MAIDEN NAME <u>Camilla Park</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>4/24</u>				16. SOCIAL SECURITY NO. <u>257016603</u>		17. INFORMANT <u>Andrew Lockett</u>		Address <u>same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis &amp; V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>								INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1960</u> to <u>Apr. 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> 19 <u>61</u> , and that death occurred at <u>5:11</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Nathan Janney</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>NATHAN JANNEY</u>						22d. ADDRESS <u>7101 Harford Rd.</u>		22b. DATE SIGNED <u>4/24/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>						ADDRESS <u>5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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(M)

1918 January 18

0-2-1075

(I)

Nathan Thayer

4-25-61  
2505 Harwood Rd.  
Leominster, Mass.



## CERTIFICATE OF DEATH

Reg. Dist. No.

03993

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood Sanatorium Towson 4, Maryland</b>		d. STREET ADDRESS <b>301. WILSTON AVE</b>	
3. NAME OF DECEASED (Type or print) <b>GLADYS First MAY Long Last</b>		4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-29-1898</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR: Months <b>62</b> Days <b>16</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOOKKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HARTFORD Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>ROBERT J. BEARD</b>		14. MOTHER'S MAIDEN NAME <b>IDA MAY MYERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-63-1847</b>	
17. INFORMANT <b>MISS A. BEARD</b>		Address <b>305 Winston Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS, FAR ADVANCED</b> DUE TO <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>002X</b> (c) <b>002X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RHEUMATOID ARTHRITIS, ACUTE BRAIN SYNDROME</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-27</b> , 19 <b>61</b> , to <b>4-16</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>4-15</b> , 19 <b>61</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Eudowood Sanatorium</b> DATE SIGNED <b>4-16-61</b>			
ACTUAL SIGNATURE <b>Milton B. Kress</b> M.D. <b>Eudowood Sanatorium</b>			
PHYSICIAN'S NAME (Type) <b>Milton B. Kress</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-19-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd.</b>	
24a. REC'D BY REGISTRAR <b>DATE APR 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kress</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03994

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1201 Francis Avenue</b>		d. STREET ADDRESS <b>1201 Francis Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>M.</b> Last <b>Lowman</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 14, 1879</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Ring</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Zimmerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Clarence E. Lowman</b>		Address <b>1201 Francis Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr Myocarditis</b> DUE TO (c) <b>Arterial Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>6 mo</b> <b>5 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 5, 1961</b> to <b>Apr 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>Apr 9, 1961</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>B. Bruce Brumbaugh, M.D.</b>		22b. DATE SIGNED <b>Apr 10, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. Bruce Brumbaugh, M.D.</b>		22d. ADDRESS <b>5609 Main Street Elkridge 27, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/12/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>Apr 12 '61</b>	
ADDRESS <b>4107 Wilkens Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Flann</b>	

1944

CENTRAL DISTRICT

00000

Baltimore

Baltimore

1201 Francis Avenue

1201 Francis Avenue

W. Loman

W. Loman

April 10, 1944

Home White

Oct. 14, 1943

Housewife

Maryland

U.S.

David H. H.

David H. H.

none

Clarence A. Loman 1201 Francis Ave.

no

1944/45 London South Germany Baltimore, Maryland

Howard H. H. 1107 Wilson Ave.

1943 Main Street 1107 Wilson Ave.

03995

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Pikesville</b>		c. LENGTH OF STAY IN 1b <b>5 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural- Pikesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>613 McHenry Rd. Balto. 8</b>				d. STREET ADDRESS <b>1 613 McHenry Rd. Balto.8</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Amanda</b>		First <b>B.</b>		Middle <b>Macken</b>		Last <b>April 3 19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 31, 1876</b>	
9. AGE (In years lost birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Beyer</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Walter H. Macken, 7233 Windsor Mill Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Information of age</b> <b>Generalized arteriosclerosis</b> <b>Asthma (Severe Allergic)</b>		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4 19 61</b> to <b>April 3 19 61</b> , that (I) (we) last saw the deceased alive on <b>April 3 19 61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Thomas E. Abbott</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas Abbott</b>				22d. ADDRESS <b>4509 Liberty Heights Ave. Balto.7, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lorna Beers</b>				25a. REC'D BY REGISTRAR DATE <b>APR 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

03300

CERTIFICATE OF DEATH

1000



RECEIVED



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4002

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03996

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville Balto. Co.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8426 Loch Raven Blvd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Md.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville Balto. Co. Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nettie</u> First <u>M</u> Middle <u>Maenner</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1884</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Brockmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brockmeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-9630</u>	
17. INFORMANT <u>Mr John B. Maenner</u>		Address <u>Balto. 12, Md.</u> <u>4531 Northwood Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1</u> DUE TO <u>Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema - bronchectasia</u> (c) <u>Hypertensive cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 13, 1961</u> to <u>4-5, 1961</u> , that (I) (we) lost the deceased on <u>4-5, 1961</u> and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Richard R. Rigler</u>		22b. DATE SIGNED <u>Sept 13, 1961</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1 West Overlea Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-10-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Joseph Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Fullerton Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassehn Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>	
ADDRESS <u>7461 Belair Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

38950

CERTIFICATE OF DEATH

38950

(M)

(I)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03997									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>46 yr</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1532 Claridge Rd</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>1532 Claridge Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Mary</b>			First Middle Last <b>Markelonis</b>			4. DATE OF DEATH Month Day Year <b>April 11, 1961</b>			
5. SEX <b>Fem</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT-20, 1917</b>		9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ant Kurn</b>					14. MOTHER'S MAIDEN NAME <b>Ant Kurn</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give year or dates of service)</b>				16. SOCIAL SECURITY NO. <b>215-10-7014</b>		17. INFORMANT <b>George Markelonis</b> Address <b>1532 Claridge Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO (b) <b>Hypertensive cardio vascular disease</b> DUE TO (c) <b>Generalized Arterio sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4-11-61</b> ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b> EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M.D.</b> Address (Street, city, town, or county) <b>1010 Leeds Ave</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-15-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LODON PARK CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>FREDERICK RD. MD.</b>			
23. FUNERAL DIRECTOR <b>Chas W Fairbanks</b>						24a. REC'D BY REGISTRAR DATE <b>APR 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1003

1003



NAVY AND MARINE CORPS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BEFORE ME, the undersigned authority, on this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing certificate, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_  
Medical Examiner

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4004

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03998

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Lutherville</b>		c. LENGTH OF STAY IN 1b <b>8 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>211 Lincoln Ave. Lutherville</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville, Md.</b>	
d. STREET ADDRESS <b>211 Lincoln Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Edwin</b> Last <b>Martin</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Color</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1883</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltio. Transit Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William B. Martin</b>		14. MOTHER'S MAIDEN NAME <b>MARY Fitch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-1523</b>	
17. INFORMANT <b>Mr. Joseph W. Martin, 211 Lincoln Ave.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1960</b> to <b>APR 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>APR 11, 1961</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>William A. Pillsbury</b>		22b. DATE SIGNED <b>4/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>William A. Pillsbury</b>		22d. ADDRESS <b>2060 York Rd Timonium Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 18, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pikesville 8, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Naval, Pikesville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

5005

CERTIFICATE OF DEATH

032308

State of Maryland  
County of Baltimore  
City of Baltimore  
I, the undersigned, being a duly qualified physician, do hereby certify that on the 11th day of April, 1915, at the City of Baltimore, Maryland, died \_\_\_\_\_, of the County of Baltimore, State of Maryland, who was born on the \_\_\_\_\_ day of \_\_\_\_\_, 18\_\_\_\_, at \_\_\_\_\_, \_\_\_\_\_, Maryland.  
The cause of death was \_\_\_\_\_  
Signed and attested at \_\_\_\_\_, Maryland, this \_\_\_\_\_ day of \_\_\_\_\_, 1915.  
\_\_\_\_\_  
Physician  
\_\_\_\_\_  
Witness



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co/</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>629 Orpington Rd. Catonsville</b>												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Baltimore Co. Catonsville</b> d. STREET ADDRESS <b>629 Orpington Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) <b>IRIS ANTHONY MASTEN</b>						4. DATE OF DEATH <b>April 10 1961</b>						5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>10/20/1883</b> 9. AGE (in years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country) <b>Chestertown Md.</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																	
13. FATHER'S NAME <b>Jonathan Anthony</b>						14. MOTHER'S MAIDEN NAME <b>? [unclear]</b>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Barbara Matsen 629 Orpington Rd.</b> Address																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>350X</b> IMMEDIATE CAUSE (a) <b>Acute Cardiac failure</b> DUE TO (b) <b>Cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Peripneumonic disease (Paralytic Agitation)</b>												INTERVAL BETWEEN ONSET AND DEATH																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>[Signature]</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>GEORGE S. M. KLEFFER MD</b> Address (Street, city, town, or county) <b>610 [unclear]</b> DATE SIGNED <b>April 10 61</b>																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>4/13/61</b>						22c. NAME OF CEMETERY OR CREMATORY <b>Lakeside M E Cemetery</b>						22d. LOCATION (City, town, or country) (State) <b>Kent Co. Delaware</b>																	
23. FUNERAL DIRECTOR <b>John M. Weber Jr</b> ADDRESS <b>5311 Edmondson Ave</b>												24a. REC'D BY REGISTRAR <b>APR 13 '61</b> DATE						24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>																	

100000

DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1000

(M)

1000

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04000

<b>1. PLACE OF DEATH</b> e. COUNTY <span style="margin-left: 100px;">Baltimore</span> <span style="margin-left: 100px;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <span style="margin-left: 50px;">Maryland</span> b. COUNTY <span style="margin-left: 50px;">Baltimore</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 40px;">Timonium</span>		c. LENGTH OF STAY IN 1b <span style="margin-left: 40px;">X</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 40px;">Timonium</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="margin-left: 40px;">2346 York Road</span>				d. STREET ADDRESS <span style="margin-left: 40px;">2346 York Road</span>			
<b>3. NAME OF DECEASED</b> (Type or print) <span style="margin-left: 20px;">Mrs.</span> <span style="margin-left: 20px;">Bessie</span> <span style="margin-left: 20px;">M.</span> <span style="margin-left: 20px;">McConnell</span>				<b>4. DATE OF DEATH</b> Month <span style="margin-left: 20px;">April</span> Day <span style="margin-left: 20px;">2,</span> Year <span style="margin-left: 20px;">19 61</span>			
<b>5. SEX</b> <span style="margin-left: 40px;">Female</span>	<b>6. COLOR OR RACE</b> <span style="margin-left: 40px;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="margin-left: 40px;">June 15, 1883</span>	<b>9. AGE</b> (In years last birthday) <span style="margin-left: 40px;">77 yrs.</span>	<b>IF UNDER 1 YEAR</b> Months <span style="margin-left: 20px;"></span> Days <span style="margin-left: 20px;"></span>		
<b>10e. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="margin-left: 40px;">At Home</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="margin-left: 40px;">Maryland</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="margin-left: 40px;">U S A</span>			
<b>13. FATHER'S NAME</b> <span style="margin-left: 40px;">Joshua Jones</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="margin-left: 40px;">Margaret Melvin</span>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="margin-left: 40px;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="margin-left: 40px;"></span>		<b>17. INFORMANT</b> <span style="margin-left: 40px;">Mrs. Doris F. Warehine</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 40px;">arterio sclerotic CardioVascular Disease</span> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)				INTERVAL BETWEEN ONSET AND DEATH <span style="margin-left: 40px;"></span>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <span style="margin-left: 20px;"></span> p.m. <span style="margin-left: 20px;">19</span>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <span style="margin-left: 20px;">August 1st 1956</span> to <span style="margin-left: 20px;">April 1st 1961</span> , that (I) (we) last saw the deceased alive on <span style="margin-left: 20px;">April 1st 1961</span> , and that death occurred at <span style="margin-left: 20px;">11 P.M.</span> from the causes and on the date stated above.							
<b>22e. SIGNATURE</b> <span style="margin-left: 40px;">M. K. Quinn</span> M.D.				<b>22b. DATE SIGNED</b> <span style="margin-left: 40px;">4/4/61</span>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <span style="margin-left: 40px;">M. KEVIN QUINN MD</span>				<b>22d. ADDRESS</b> <span style="margin-left: 40px;">1927 YORK RD, TIMONIUM, Md.</span>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="margin-left: 40px;">Burial</span>		<b>23b. DATE THEREOF</b> <span style="margin-left: 40px;">April 5, 1961</span>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <span style="margin-left: 40px;">Druid Ridge</span>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="margin-left: 40px;">Burgee Funeral Home</span>				<b>25a. REC'D BY REGISTRAR</b> <span style="margin-left: 40px;">APR 5 '61</span>			
<span style="margin-left: 40px;">3631 Falls Road</span> <span style="margin-left: 40px;">Baltimore</span>				<b>25b. REGISTRAR'S SIGNATURE</b> <span style="margin-left: 40px;">Arthur S. Hines</span>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO : Mr. J. Edgar Hoover  
FROM : Mr. [illegible]  
SUBJECT : [illegible]  
RE : [illegible]  
DATE : [illegible]  
[illegible text continues]

[Faint, mostly illegible text and markings at the bottom of the page, including what appears to be a signature and date.]

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04001

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>3 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;"><b>Howard County</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Madison</b> d. STREET ADDRESS <b>09X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>FILMORE</b> <span style="float: right;"><b>McCoy</b></span> First Middle Last		<b>4. DATE OF DEATH</b> <b>April 3 1961</b> Month Day Year		<b>9. AGE</b> (In years last birthday) <b>42</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Colored</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 12, 1919</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Grain Co</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Leesburg Georgia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b> <b>13. FATHER'S NAME</b> <b>John McCoy</b>		<b>14. MOTHER'S MARDEN NAME</b> <b>Alice Richardson</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give war and dates of service) <b>WW-11</b>		<b>16. SOCIAL SECURITY NO.</b> <b>253-24-7359</b> <b>17. INFORMANT</b> <b>Clin Rec VAH Balto Md Ft Howard Division</b> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</b> DUE TO (c) <b>UNKNOWN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that</b> (X) (this hospital) attended the deceased from <b>March 31 1961</b> to <b>April 3, 1961</b> that (u) (we) last saw the deceased alive on <b>April 3, 1961</b> and that death occurred at <b>8:10 p.m.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>22b. PHYSICIAN'S NAME</b> (Type) <b>THOMAS F. CRAHAN, M.D.</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>4/4/61</b> <b>22d. ADDRESS</b> <b>VAH BALTO. MD. FT HOWARD DIVISION</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>4/10/1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MALONE CEMETERY</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 10 '61</b> <b>DATE</b>			
<b>St. Clair Funeral Home, Cambridge, Md.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Kraus</i>					

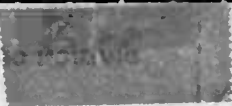
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
4008 Item 14 File 6284 4/21/61 iwk 04002														
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armecost Nursing Home</u>					d. STREET ADDRESS <u>908 Rappaix Court</u>									
3. NAME OF DECEASED (Type or print) <u>Peter</u>					4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1961</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P. Lorillard Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME <u>Peter McEvoy</u>					14. MOTHER'S MAIDEN NAME <u>CATHERINE unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>					16. SOCIAL SECURITY NO. <u>219-28-1498</u>					17. INFORMANT Address <u>Mrs A. Gordon Armstrong Pratt &amp; Montrose</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450-0</u> DUE TO (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>31 wks</u> <u>10 yrs</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1960</u> to <u>April 13, 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>April 13, 1961</u> , and that death occurred <u>2:30 PM</u> , from the causes and on the date stated above.														
22a. SIGNATURE <u>Charles F. O'Donnell</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u>					22d. ADDRESS <u>7501 YORK RD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			23b. DATE THEREOF <u>4-18-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD</u>							
24 FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>					ADDRESS <u>5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04003

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>		d. STREET ADDRESS <u>Ridge Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridge Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Belle McGraw</u>		4. DATE OF DEATH <u>April 22, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 22 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Taswell Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Alley</u>		14. MOTHER'S MAIDEN NAME <u>Fanny Empsweller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Hazel White, Freeland Md. R.D.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442X</u> DUE TO (b) <u>Hypertensive Cardio Renal</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>—</u>			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-25-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>		24. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>APR 26 '61</u>	

VS. A15ME  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4010

04004

1. PLACE OF DEATH a. COUNTY Baltimore County			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland			c. LENGTH OF STAY IN 1b 4 mos. 12 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital			d. STREET ADDRESS 101 Woodlawn Avenue		
3. NAME OF DECEASED (Type or print) First Middle Last Gerald William McNally			4. DATE OF DEATH Month Day Year 4 12 19 61		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-06	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Guard		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
13. FATHER'S NAME Philip F. McNally			14. MOTHER'S MAIDEN NAME Amy B. Howard		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 212-28-5320		17. INFORMANT Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoxia of heart during Pneumonectomy DUE TO Corinary sclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Empyema in right pleural space DUE TO Pulmonary Tuberculosis, far advanced (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 18 years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none.			
20c. TIME OF INJURY Month, Day, Year None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) Annapolis		20g. (County) Anne Arundel		20h. (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE D.D. CAPLES, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) D.D. CAPLES, M.D.			DATE SIGNED 4-12-61		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16, 61		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	
23. FUNERAL DIRECTOR Hopping Funeral Home		22d. LOCATION (City, town, or country) Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE APR 17 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04005

4011

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Forest Haven Conv. Home-315 Ingleside Ave. Hood Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Newton Dennison Mereness</b>			4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1961</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1868</b>		9. AGE (In years last birthday) <b>92</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Professor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Archivist</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Mereness</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Miss Elizabeth Martindale-Same</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE - CVA - CORONARY OCCLUSION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Pikesville</b>	(County) <b>Maryland</b> (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> to <b>4/17</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/17</b> , 19 <b>61</b> , and that death occurred at <b>8:00 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John H. Shaw</b>		M.D.	ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4/18/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW M.D.</b>		22d. ADDRESS <b>5800 EDWARDS AVE. BALDWIN</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 19, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) <b>Pikesville, Maryland</b> (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Johnson</b>		ADDRESS <b>North ... Ave. Baltimore</b>		25a. REC'D BY REGISTRAR <b>APR 19 1961</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

4012

04006

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>10 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>1409 N. BROADWAY.</b>	
3. NAME OF DECEASED (Type or print) <b>BERTHA DOVE MILLER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-1878</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM EDWARD GREGGON</b>		14. MOTHER'S MAIDEN NAME <b>ISABEL A. CARROLL.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-28-6668 D</b>	
17. INFORMANT <b>Frank L. Smith</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 years.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-13</b> <b>1962</b> , to <b>4-13</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>4-12</b> <b>1961</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>4/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4013

## CERTIFICATE OF DEATH

04007

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>9 days</b>		d. STREET ADDRESS <b>347 E. 29th Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JAMES</b> Middle <b>W.</b> Last <b>MILLER</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>10</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>November 30, 1894</b>	
<b>9. AGE</b> (In years last birthday) <b>66</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Real Estate Broker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Real Estate</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Charles S. Miller</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary E. Dietrich</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b> <b>WW I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>WW I</b>	
<b>17. INFORMANT</b> <b>Clin. Records. VA Hospital, Balto. Md.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>RIGHT LOWER LOBE PNEUMONITIS, CAUSE UNKNOWN</b> <b>053.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>SEPTICEMIA</b> DUE TO <b>UNKNOWN</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <b>OSTEOMYELITIS RIGHT FIRST METATARSAL JOINT</b>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>19</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>April 1, 1961</b>		<b>20f. (City or town)</b> (County) (State) <b>Baltimore, Md.</b>	
<b>21. I certify that</b> (this hospital) <b>attended the deceased from April 1, 1961, to April 10, 1961, that (s) (we) last saw the deceased alive on April 10, 1961, and that death occurred at 9:15 PM from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <b>Thomas F. Crahan</b> M.D. <b>22b. DATE SIGNED</b> <b>4/11/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>THOMAS F. CRAHAN, M. D.</b>		<b>22d. ADDRESS</b> <b>VAH, BALTO. MD. FT HOWARD DIV.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>5-14-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore 28, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Henry F. Jenkins</b>		<b>25a. REC'D BY REGISTRAR</b> <b>APR 12 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Kraus</b>		<b>25c. DATE</b> <b>APR 12 '61</b>	



Director

Mr. Hoover

Washington, D.C.

April 10, 1935

Mr. Tolson

Mr. E.A. Tamm

Mr. Clegg

Mr. Glavin

Mr. Ladd

Mr. Nichols

Mr. Rosen

Mr. Tracy

Mr. Carson

Mr. Egan

Mr. Gurnea

Mr. Hendon

Mr. Pennington

Mr. Quinn

Mr. Nease

Mr. Gurnea

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **04008**

**4014**

1. PLACE OF DEATH a. COUNTY <b>BALT. more</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. LENGTH OF STAY IN 1b <b>7 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2936 POTTY HILL Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LUCIA</b> Middle <b>A</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 11 - 1881</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AD Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Rev John Hooper</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Neuman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Louise Basham</b>		Address <b>4900 Hartford Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>central Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Generalized arteriosclerosis</b> (b) DUE TO <b>5 yrs.</b> (c) <b>1 day</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 10, 1955</b> , to <b>April 29, 1961</b> , that I last saw the deceased alive on <b>April 27, 1961</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George Sawyer</b>				ADDRESS (Street, city or town, state) <b>4808 Hartford Rd</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE SAWYER</b>				DATE SIGNED <b>5/1/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>May 2 - 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>BALT. more Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. F. EVANS &amp; Son</b>				ADDRESS <b>8802 Hartford Rd</b>			
24a. REC'D BY REGISTRAR <b>MAY 2 '61</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04009**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 116 German Hill Rd. 22, Md.</b>				d. STREET ADDRESS <b>116 German Hill Rd. 22, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anthony</b> First <b>ALFRED</b> Middle <b>Milsi</b> Last				4. DATE OF DEATH Month <b>4</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>April 1, 1898</b>		9. AGE (In years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wire Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-3335</b>		17. INFORMANT <b>Mrs. Margaret Rose Milsi</b> Address <b>116 German Hill Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C. Collins</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Jack C. Collins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-11-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		22d. LOCATION (City, town, or county) (State) <b>German Hill Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN J. DUDA</b>				ADDRESS <b>7922 Wise Ave. 22, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 13 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

4016

Items 5 & 6 Film G287 5/16/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 04010

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>227 Detroit Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Minotelli</u> Last <u>Minotelli</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 18, 1870</u>		9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>RUGGERIO CUPOLI</u>				14. MOTHER'S MAIDEN NAME <u>CARMEN CAIRELLI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Miss Mary D'Ambrosio 227 Detroit Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardio-vascular disease</u> DUE TO (c) <u>Generalized arterio-sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 yrs</u> <u>30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 20, 1961</u> to <u>April 28, 1961</u> , that I last saw the deceased alive on <u>4/20, 1961</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7001 Mornington Rd Dundalk 23, Md</u> DATE SIGNED <u>4-2</u>							
ACTUAL SIGNATURE <u>Eugene F Navy</u> M.D.				PHYSICIAN'S NAME (Type) <u>Eugene F Navy</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>  </u>		<u>2/5/61</u>		<u>Holy Cross Cem</u>		<u>Clarksburg, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Zannini Jr.</u>				ADDRESS <u>312 S. Highland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 8 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18





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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4018											
04012											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4140 Beechwood Road</u>						d. STREET ADDRESS <u>4140 Beechwood Road</u>					
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary Ellen Mitchell</u>						4. DATE OF DEATH Month <u>April</u> Day <u>8th</u> Year <u>19 61</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1879</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mingo Junction, Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Cleary</u>						14. MOTHER'S MAIDEN NAME <u>Mary Roach</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Otto H. Duker, 3rd,</u>		Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>287X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (c) <u>Obesity</u> causing the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had a previous cerebral hemorrhage 1960</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1960</u> to <u>April 8, 1961</u> that (I) (we) last saw the deceased alive on <u>Apr 7, 1961</u> , and that death occurred at <u>1430</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Morris A. Jacobs</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/8/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Morris A. Jacobs M.D.</u>						22d. ADDRESS <u>1010 North Point Rd. Belts 24 Ind</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>						ADDRESS <u>5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **04013**

**4019**

1. PLACE OF DEATH a. COUNTY <b>BALTO Co</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO Co</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X PARKVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3013 MORE LAND AVE</b>		d. STREET ADDRESS <b>13013 MORE LAND AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>MORFE</b> Last <b>MORFE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 22-1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (State or foreign country) <b>ITLY</b>
13. FATHER'S NAME <b>DOMINIC MORFE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-01-3118</b>	
17. INFORMANT <b>FRANK MORFE</b>		Address <b>3201 Chesley Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>523.0 Congestive failure</b> DUE TO <b>Fibrosis with silicosis severe</b> (b) <b>and myocardial degeneration</b> DUE TO <b>Generalized arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2-3 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr 1</b> , 19 <b>61</b> , to <b>Apr 2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Apr 1</b> , 19 <b>61</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9005 Harford Road</b> DATE SIGNED <b>Apr 2 1961</b>			
ACTUAL SIGNATURE <b>Frank T. Kasik, Jr.</b>		M.D. <b>9005 Harford Road</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Frank T. Kasik, Jr.</b>		<b>Baltimore 14, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4-4-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. F. EVANS &amp; SON</b>		ADDRESS <b>8802 HARTFORD RD.</b>	
24a. REC'D BY REGISTRAR <b>DATE APR 4 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF CHURCH OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWER	
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43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWER	
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61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWER		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWER	
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79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWER		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWER	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4020 CERTIFICATE OF DEATH 04014

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>408 Maryland Ave.</u>		d. STREET ADDRESS <u>1408 MARYLAND AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW B MUELLER (MILLER)</u>		4. DATE OF DEATH Month Day Year <u>APRIL 11 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 10, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crain Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Mueller</u>		14. MOTHER'S MAIDEN NAME <u>Eva Bartell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>216-10-3181</u>	
17. INFORMANT Address <u>CONSTANCE MUELLER (same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>540.0 GASTRIC HEMORRHAGE</u> DUE TO (b) <u>GASTRIC ULCER</u> DUE TO (c) <u>540.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>2 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS, HYPERTENSION, OLD HEMIPLEGIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 16 1950</u> to <u>APR. 11 1961</u> , that (I) (we) last saw the deceased alive on <u>APR 10 1961</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Mueller</u> M.D.		22b. DATE SIGNED <u>4/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MUELLER MD</u>		22d. ADDRESS <u>108 S. TAYLOR AVE BALTO 21 MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-14-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u> ADDRESS <u>418 Eastern Blvd.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 17 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CENTRAL BANK OF CANADA

(M)

(I)

CHIEF CLERK

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

4021

04015

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4214 Cardwell Ave/</b>				d. STREET ADDRESS <b>4214 Cardwell Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Lawrence L. Mullen</b>		First Middle Last		4. DATE OF DEATH <b>April 21, 1961</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 28, 1904</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Consultant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Harry L. Mullen</b>		14. MOTHER'S MAIDEN NAME <b>Mary Butler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-6789</b>		17. INFORMANT <b>Mrs. Mary M. Mullen</b>		Address <b>4214 Cardwell Ave. 6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>155.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Carcinoma Cholangiodytic with metastasis to Lf Lung.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Jan 61</b>		20f. (City or town) (County) (State) <b>APR 61</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 61</b> to <b>APR 61</b> , that (I) (we) last saw the deceased alive on <b>April 20, 1961</b> , and that death occurred at <b>1961</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Frank T. Kasik</b>		22b. PHYSICIAN'S NAME (Type) <b>FRANK T. KASIK</b>		22c. ADDRESS <b>9005 Harford Rd</b>	
22d. DATE <b>4/24/61</b>		22e. SIGNATURE <b>14</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-25-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sarah Funeral Home</b>		25a. REC'D BY REGISTRAR <b>7401 Belair Rd</b>		25b. REGISTRAR'S SIGNATURE <b>APR 26 '61</b>		25c. REGISTRAR'S SIGNATURE <b>Charles S. Kneass</b>	

100-100000

CERTIFICATE OF DEATH

100-100000

(M)

(1)

*[Faint, mostly illegible handwritten text, possibly containing names and dates]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4022

CERTIFICATE OF DEATH

04016

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2829 Linwood Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>2829 Linwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>M.</u> Last <u>Murphy</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 61</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 -28-1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>John J. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A. Hunt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT <u>Mrs Gertrude M. McWilliams</u> Address <u>same</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Longstanding Heart failure &amp; pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> (c) <u>Arterio sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>4/4</u> , 19 <u>55</u> to <u>April 22, 1961</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>April 22</u> , 19 <u>61</u> , and that death occurred at <u>2</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles R. Goldsborough</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>  </u>
22c. PHYSICIAN'S NAME (Type) <u>Charles R. Goldsborough, M.D.</u>		22d. ADDRESS <u>2923 Saint Paul Street Balto. 18, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4-26-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore, Md.</u>	23d. LOCATION (City, town or county) (State) <u>  </u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>		25a. RECEIVED BY REGISTRAR <u>APR 25 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinare</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4023 Items 8 & 9 Film G285 4/24/61 iwk				04017							
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN lb <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>5121 GOLDEN RING</b>							
1. NAME OF DECEASED (Type or print) <b>WILLIAM M Detrick</b> First Middle Last 2. DATE OF DEATH <b>APRIL 16 1961</b> Month Day Year				3. NAME OF DECEASED (Type or print) <b>WILLIAM M Detrick</b> First Middle Last 4. DATE OF DEATH <b>APRIL 16 1961</b> Month Day Year							
5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>APRIL 30 1906</b> Month Day Year 9. AGE (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Company</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>BALTO CITY</b> 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				13. FATHER'S NAME <b>William Nake</b> 14. MOTHER'S MAIDEN NAME <b>Anna Ripken</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>212-05-2993</b>				17. INFORMANT <b>Mrs Emily Nake</b> Address <b>7121 Golden Ring Rd.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crownary Occlusion</b> 420.1 DUE TO <b>Arteriosclerotic Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>April 15 1961</b> to <b>April 16 1961</b> , that (I) (we) last saw the deceased alive on <b>April 15 1961</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. M. Gardner</b> 22c. PHYSICIAN'S NAME (Type)				M.D. <b>Balto 6 Md.</b> 22d. ADDRESS				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4/16/61 22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>APRIL 19, 1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ZION LUTHERAN CEM.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b> ADDRESS <b>7401 Belair Road #6</b>				25a. REC'D BY REGISTRAR <b>APR 19 '61</b> DATE				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

(M)

WILLIAM BRICK WAKE

1970-1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G286 5/5/61 jwk

## CERTIFICATE OF DEATH

Reg. Dist. No.

04018

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto 14</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8820 Old Harford Rd</u>				d. STREET ADDRESS <u>18820 Old Harford</u>			
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Margaret Amelia Nesline</u>				4. DATE OF DEATH <u>Apr 22 1961</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5 1878</u>	
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>19</u> Min. <u>61</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Knaysters</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Peter Emge</u>				14. MOTHER'S MAIDEN NAME <u>Roseland Ziegler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Daughter</u>			
17. INFORMANT <u>Daughter</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial degeneration</u> (c) <u>Coronary Artery disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Send Arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>Jan</u> Day <u>19</u> Year <u>1955</u> Hour <u>a. m.</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>BALTO</u> (County) <u>MD</u> (State) <u>MD</u>							
21. I certify that I attended the deceased from <u>Jan 1955</u> to <u>Apr 1961</u> , that I last saw the deceased alive on <u>Apr 18 1961</u> , and that death occurred at <u>100 P M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Kasik</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 Harford Rd BALTO 14 MD</u>			
DATE SIGNED <u>4/22/61</u>							
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-25-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM</u>		22d. LOCATION (City, town, or county) <u>BALTO</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lanahan Jan H Home 7401 Belair Rd</u>				24a. REC'D BY REGISTRAR <u>APR 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine E. Home</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04019**

**4025**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CADONVILLE</b>				c. LENGTH OF STAY IN 1b <b>NDUNDALK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FOREST HAVEN N.H.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES A.</b> Middle <b>O</b> Last <b>STENDORF</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 24, 1884</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.		11. IF UNDER 24 HRS. Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOSEPH F. STENDORF</b>				14. MOTHER'S MAIDEN NAME <b>JOHANNA RETHMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>SADIE HERRMAN</b>				Address <b>221 PAVANCO AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 DUE TO</b> <b>ARTERIO SCLEROTIC CEREBRO-VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEMIPLEGIC PARALYSIS</b> (c) <b>DEGENERATIVE DISEASES</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/1</b> , 19 <b>59</b> , to <b>4/3</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>4/3</b> , 19 <b>61</b> , and that death occurred at <b>11:45 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5800 EDWARDS AVE. BALTIMORE, MD.</b> DATE SIGNED <b>4/3/61</b> ACTUAL SIGNATURE <b>John H. Shaw</b> M.D. PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW M.D. BALTIMORE, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-6-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ILLERICH FUNERAL HOME</b>				24a. REC'D BY REGISTRAR DATE <b>APR 10 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12 mil</u> g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armacost Nursing Home</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> g. STREET ADDRESS <u>329 Rosebank Ave</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>JOHN HENRY OTTO</u>			4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas &amp; Electric Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Simon Otto</u>			14. MOTHER'S MAIDEN NAME <u>Anna M. Koch</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-6627</u>		17. INFORMANT <u>John R. Otto</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 153.9 DUE TO (b) <u>Carcinoma large Bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>large</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>4 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1948</u> to <u>April 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 26, 1961</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/28/61</u>
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>			22d. ADDRESS <u>7501 York Rd Towson Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 29, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>			ADDRESS <u>4905 York Rd</u> DATE <u>MAY 1 '61</u>		
			25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		
			25b. REGISTRAR'S SIGNATURE		

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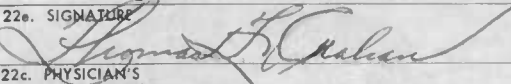

Handwritten notes, mostly illegible due to blurring and bleed-through. Some visible words include "Baltimore", "John", "Henry", "Otto", "Post", "1840", "1841", "1842", "1843", "1844", "1845", "1846", "1847", "1848", "1849", "1850", "1851", "1852", "1853", "1854", "1855", "1856", "1857", "1858", "1859", "1860", "1861", "1862", "1863", "1864", "1865", "1866", "1867", "1868", "1869", "1870", "1871", "1872", "1873", "1874", "1875", "1876", "1877", "1878", "1879", "1880", "1881", "1882", "1883", "1884", "1885", "1886", "1887", "1888", "1889", "1890", "1891", "1892", "1893", "1894", "1895", "1896", "1897", "1898", "1899", "1900".

Handwritten notes at the bottom of the page, including a large signature or name "Wm. L. Garrison" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
4027									
04021									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>14 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b> d. STREET ADDRESS <b>207 Fourth Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LONNIE G. PARKER</b>					4. DATE OF DEATH Month Day Year <b>April 26 1961</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 7, 1901</b>		9. AGE (In years last birthday) <b>60 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Repair Shop</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Craven County, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <b>/Sylvester G. Parker</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Ballard</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWI</b>					16. SOCIAL SECURITY NO. <b>239-16-9194</b>		17. INFORMANT Address <b>Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY HEMORRHAGE, MASSIVE</b> <b>163X</b> Conditions, if any, which gave rise to immediate cause (b) <b>CARCINOMA, RIGHT LUNG</b> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LUNG ABSCESS, RIGHT MID LUNG</b>								INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>2 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 12, 1961</b> to <b>April 26, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 26, 1961</b> , and that death occurred at <b>A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>					22b. DATE SIGNED <b>4/26/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>VAH, BALTO. 18, MD. FORT HOWARD DIVISION</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>4-27-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bridgeton Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>New Bern, North Carolina</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Road, Balto. 14, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>		25b. REGISTRAR'S SIGNATURE 		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4028  
CERTIFICATE OF DEATH

04022

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The House In The Pines-16FustingAve</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2426 Wilkins Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY E. PARKS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>10-6-1883</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>John Bauer</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Horn</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No/</b>	
16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT <b>Mrs. Lillian Ennis-6439Gaul1 S.E D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Hypertensive Cardio-Vascular-Renal Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>442X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour s.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-18-1961</b> to <b>4-17-1961</b> , that (I) (we) last saw the deceased alive on <b>4-15-1961</b> , and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wilmer K. Gallagher</b> M.D.		22b. DATE SIGNED <b>APR 21 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher, M.D.</b>		22d. ADDRESS <b>6209 Frederick Rd Baltimore-28, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-20-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Neppert</b>		25a. REC'D BY REGISTRAR <b>1300 Eutaw Place</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>		DATE <b>APR 21 '61</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04023

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>	c. LENGTH OF STAY IN 1b <b>LIFE</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Arthur</b> First <b>Yellott</b> Middle <b>Pindell</b> Last		4. DATE OF DEATH Month <b>APRIL</b> Day <b>17</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 23, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C. &amp; P. TELEPHONE BALTIMORE Co.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>REV. ADOLPHUS T. PINDELL</b>		14. MOTHER'S MAIDEN NAME <b>JANE YELLOTT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. ARTHUR Y. PINDELL COCKEYSVILLE, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung, ht. upper lobe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>163X</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic hypertrophy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Aug 1960</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 15</b> 19 <b>60</b> to <b>April 17</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>April 17</b> 19 <b>61</b> , and that death occurred at <b>4:15 p.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Elizabeth B. Sherrill</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill, M.D.</b>		22d. ADDRESS <b>Cockeysville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/19/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SHERWOOD</b>		23d. LOCATION (City, town, or county) (State) <b>COCKEYSVILLE, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. MEARS &amp; SON 805 N. CALVERT ST.</b>		25a. REC'D BY REGISTRAR <b>APR 19 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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DEPARTMENT OF HEALTH  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4030

04024

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>9 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>37 Larkin Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>ALFRED</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>27</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 5, 1897</b>		<b>9. AGE</b> (In years last birthday) <b>64</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cook</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>East Polaka, Florida</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Franklin Pinkston</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Fannie Wilson</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WW I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>WW I</b>				<b>17. INFORMANT</b> <b>Clinical Records, VAH, Baltimore 18, Md.</b> <b>FORT HOWARD DIVISION</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> (b) <b>CARCINOMA OF PANCREAS WITH METASTASES</b> (c) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>1 YEAR</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis, generalized. Diabetes Mellitus</b>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)																			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 18, 1961</b> to <b>April 27, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 27, 1961</b> , and that death occurred at <b>3:05 A.M.</b> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b>  <b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M.D.</b>										<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22d. ADDRESS</b> <b>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</b>						<b>22b. DATE SIGNED</b> <b>4/28/61</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>5-2-1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>National</b>				<b>23d. LOCATION (City, town or county)</b> (State) <b>Anne Arundel Md.</b>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Reese Mortuary, Wm. Reese</b>										<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 1 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Mr. [Name] [Address] [City] [State] [Zip]  
[Name] [Address] [City] [State] [Zip]  
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Mr. [Name] [Address] [City] [State] [Zip]  
[Name] [Address] [City] [State] [Zip]  
[Name] [Address] [City] [State] [Zip]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**TITIAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4031

04025

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>18 Edmondson Ridge</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kenly Bennett Pittinger</b>		4. DATE OF DEATH <b>April 29, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1896</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Service Co</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	9c. BIRTHPLACE (State or foreign country) <b>Md</b>
10. FATHER'S NAME <b>Pittinger</b>		11. MOTHER'S MAIDEN NAME <b>Bennett</b>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		13. SOCIAL SECURITY NO. <b>29 28 1463</b>	
14. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <b>Coronary thrombosis</b>		15. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		16. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
18a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		18b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19b. (City or town) (County) (State)	
20. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
21. ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b> EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M.D.</b>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>April 29, 61</b> Address (Street, city, town, or county) <b>1010 Leeds Ave (29)</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>5/1/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		23d. LOCATION (City, town, or country) (State) <b>Balto. Md</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 3 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. H.</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
4032					04026									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>									
c. LENGTH OF STAY IN TB <b>267 Days</b>					d. STREET ADDRESS <b>27 Hazel Avenue</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Philip</b> Middle <b>T</b> Last <b>Potter</b>					4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1961</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4, 1876</b>		9. AGE (In years last birthday) <b>84</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trainman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days						
13. FATHER'S NAME <b>Benjamin F Potter</b>					14. MOTHER'S MAIDEN NAME <b>Mary Connelly</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>SAW</b>					16. SOCIAL SECURITY NO. <b>705-05-6084</b>					17. INFORMANT <b>Clin Rec VAH Baltimore Md - Ft Howard Division</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UPPER GASTRO-INTESTINAL BLEEDING, UNDETERMINED ETIOLOGY</b> (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH DECOMPENSATION/</b>										3 WEEKS (UNKNOWN)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL ARTERIOSCLEROSIS</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <b>19</b> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that <b>MD</b> (this hospital) attended the deceased from <b>July 14, 1960</b> to <b>April 7, 1961</b> , that <b>MD</b> (we) last saw the deceased alive on <b>April 7, 1961</b> , and that death occurred at <b>6:30 p.m.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Arthur T. Faulk</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED <b>4-8-61</b>				
22c. PHYSICIAN'S NAME (Type) <b>Arthur T. Faulk M.D.</b>					22d. ADDRESS <b>VAH Baltimore Md - Ft Howard Division</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>			23d. LOCATION (City, town or county) <b>Baltimore Maryland</b>			(State)				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H Hubbard</b>					ADDRESS <b>4107 Wilkins Ave Baltimore 29 Md</b>		25a. REC'D BY REGISTRAR <b>APR 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4033

04027

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4y 11dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>110 Parkin Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Overby</b> Last <b>Powell</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1911</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Bunch</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Beck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>—</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>692.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Retroperoneal Abscess</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>—</b> o. m. <b>—</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>April 4, 1961 to April 13, 1961</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1961</b> to <b>April 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 13, 1961</b> and that death occurred at <b>3:45</b> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>4-13-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/17/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		23d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. DATE <b>APR 17 '61</b>	

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CHIEF A. A. W. M.

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CERTIFICATE OF HEALTH

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DEPARTMENT OF HEALTH  
OFFICE OF THE ASSISTANT SECRETARY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4034

## CERTIFICATE OF DEATH

04028

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5 Cedarwood Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>5 Cedarwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Jessie X. Pugh</u>				<b>4. DATE OF DEATH</b> <u>April 18, 19 61</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 15, 1883</u>	
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Homemaker</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Charles C. Spies</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sophie E ?</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war and dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>			
<b>17. INFORMANT</b> <u>Miss Irma E. Pugh-5 Cedarwood Road # 28</u>				<b>Address</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of urinary bladder</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 days</u> <u>10 mo.</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7/29, 1960</u> <b>to</b> <u>4/18, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>4/18, 1961</u> <b>and that death occurred at</b> <u>1:15 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Robert A. Reiter</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert A. Reiter M.D.</u>				<b>22d. ADDRESS</b> <u>3408 Windsor Ave.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4-21-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Baltimore, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>North ...</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 20 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. House</u>	

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Robert A. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4035

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04029

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. LENGTH OF STAY IN 1b <u>7</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5331 Hologwood Rd.</u>		d. STREET ADDRESS <u>5331 Hologwood Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ernest</u> First <u>Michael</u> Middle <u>Reitz</u> Last		4. DATE OF DEATH <u>April 5/61</u> 19 <u>61</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1899</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Reitz</u>		14. MOTHER'S MAIDEN NAME <u>Helena</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>420.1</u>	
17. INFORMANT <u>Evelyn Reitz</u> Address <u>5331 Hologwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cause Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>3 hours</u> DUE TO (c) <u>Interval between onset and death</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> 19 <u>60</u> to <u>4/5</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>61</u> , and that death occurred on <u>1/34</u> M, from the causes on and on the date stated above.			
22a. SIGNATURE <u>Dr. J. Miller</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1047 TROUBLESHOOTER, BALTIMORE 25, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Karraine</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F. W. 4101 Edmondson</u>		25a. REC'D BY REGISTRAR <u>APR 10 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **04030**

**4036**

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>DUNDALK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>TERRY</b> Middle <b>JOSEPH.</b> Last <b>RICHARDSON</b>		4. DATE OF DEATH Month <b>4</b> - Day <b>18</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-11-56</b>
9. AGE (In years last birthday) <b>4</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>6</b> Hours <b>15</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>WILLIAM H. RICHARDSON.</b>	
14. MOTHER'S MAIDEN NAME <b>JULIA J. MURRAY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>W. H. RICHARDSON, 7546 LIVES LANE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar PNEUMONIA</b> DUE TO <b>351X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Palsy</b> DUE TO <b>INANITION</b> (c) <b>3 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>SINCE BIRTH</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1957</b> to <b>April 18, 1961</b> , that I last saw the deceased alive on <b>April 18, 1961</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Morris A. Jacobs</b>		ADDRESS (Street, city or town, state) <b>1010 North Point Rd Baltimore 24 Md</b>	
PHYSICIAN'S NAME (Type) <b>MORRIS A. JACOBS</b>		DATE SIGNED <b>4/18/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-19-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabrowski 1005 Dundalk Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 20 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04031

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>139 Elizabeth Avenue</b>		d. STREET ADDRESS <b>139 Elizabeth Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Naomi</b> Middle <b>A.</b> Last <b>Rinick</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 24, 1889</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Chambersburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Schuchman</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Biedel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Garnet A. Rinick</b>		Address <b>139 Elizabeth Ave. #27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency due to Atherosclerosis</b> DUE TO (c) <b>2 mos</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Urinary Tract Infection 8 yrs</b> <b>Chronic Diverticulitis of Recto-Sigmoid Colon</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 22, 1954</b> to <b>April 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 31, 1961</b> , and that death occurred on <b>April 5, 1961</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>C. Arthur Rossberg, M.D.</b>		22b. ADDRESS <b>2436 Washington Blvd.</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Arthur Rossberg, M.D.</b>		22d. ADDRESS <b>2436 Washington Blvd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		25a. REC'D BY REGISTRAR <b>APR 10 1961</b>	
ADDRESS <b>4107 Wilkens Avenue</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



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CERTIFICATE OF DEATH

1934

(M)

Residence

Residence

135 Lincoln Avenue

135 Lincoln Avenue

April 5, 1934

Rate of

Death

Jan. 2, 1934

Female

Grandmother, P. U. S. A.

Housewife

James Biedel

John Seashman

(1)

None

None

C. Arthur Weaver, M.D., 2435 Madison Ave. N.Y.C.

Interment in the City of New York, New York

Interment in the City of New York, New York



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04032

1. PLACE OF DEATH o. COUNTY <b>BALTO.</b> M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> X d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>110 BIRCHWOOD RD.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b> X d. STREET ADDRESS <b>110 BIRCHWOOD RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAMUEL M. ROBERTS</b>				4. DATE OF DEATH Month Day Year <b>APRIL 9 1961</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>AUG. 8, 1870</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN-RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN ROBERTS</b>				14. MOTHER'S MAIDEN NAME <b>FRANCES MOORE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MD. Farwick - 110 BIRCHWOOD RD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE CEREBRAL</b> <b>422.1</b> DUE TO <b>ARTERIOSCLEROTIC CV Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b> <b>10 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1-6</b> 19 <b>56</b> to <b>4-9</b> 19 <b>61</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4-8</b> 19 <b>61</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John F. Schaefer</b>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>4-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John F. Schaefer, M.D.</b>		22d. ADDRESS <b>401 Random Rd - Balto. 29 Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-11-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brimmont Cemetery</b>		23d. LOCATION (City, town, or county) <b>Balto.</b>		(State) <b>MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Julius Cavanaugh, H. Catonsville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 14 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>		

0-7683

CERTIFICATE OF DEATH

0-7683

17

Blank certificate form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4039					04033				
Item 9 Film G285 1/17/61 mh									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN lb <b>37 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			d. STREET ADDRESS <b>1103 W. Mulberry Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JOHN</b>			First <b>H.</b> Middle <b>ROBINSON</b> Last		4. DATE OF DEATH <b>April 9 1961</b>		Month <b>April</b> Day <b>9</b> Year <b>1961</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 13. 1888</b>		9. AGE (In years last birthday) <b>73 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Tower Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Robinson</b>					14. MOTHER'S MAIDEN NAME <b>Anna Allen</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>218-22-9241 Clin. Records. VAH, Balto. Md. Ft. Howard Division</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, RECENT</b> DUE TO (b) <b>CARCINOMA GALL BLADDER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>JAUNDICE DUE TO #2</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>March 3, 1961 to April 9, 1961</b>		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 3, 1961</b> to <b>April 9, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 9, 1961</b> , and that death occurred at <b>11:15P</b> from the causes and on the date stated above.									
22a. SIGNATURE <i>Thomas F. Crahan</i> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/10/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>					22d. ADDRESS <b>VAH, BALTIMORE, MD. - FT HOWARD DIVISION</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-13-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>					ADDRESS <b>Funeral Home 1808 N. Monroe St. Balto 17, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 12 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Charles L. Thomas</i>

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4040

## CERTIFICATE OF DEATH

04034

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> c. LENGTH OF STAY IN 1b <u>Arbutus</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1133 Gloriette</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> d. STREET ADDRESS <u>1133 Gloriette Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mariann C. Robinson</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>April 8/61</u> Month Day Year									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 18, 1920</u>		<b>9. AGE</b> (In years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lewis Candy</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto. Md</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. a.</u>									
<b>13. FATHER'S NAME</b> <u>Walter Scheufele</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Hartman</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes give year or dates of service) _____				<b>16. SOCIAL SECURITY NO.</b> <u>Clifton M. Robinson Sr</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 30%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>410 X</u> </td> <td style="width: 70%;"> <b>Congestive Heart Failure</b> </td> </tr> <tr> <td> <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> <td> <b>(b)</b>  <b>Rheumatic Heart Disease with mitral stenosis</b> </td> </tr> <tr> <td></td> <td> <b>(c)</b>  <b>Squamous cell carcinoma of the cervix of the uterus.</b> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>410 X</u>	<b>Congestive Heart Failure</b>	<b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>	<b>(b)</b> <b>Rheumatic Heart Disease with mitral stenosis</b>		<b>(c)</b> <b>Squamous cell carcinoma of the cervix of the uterus.</b>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>410 X</u>	<b>Congestive Heart Failure</b>												
<b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>	<b>(b)</b> <b>Rheumatic Heart Disease with mitral stenosis</b>												
	<b>(c)</b> <b>Squamous cell carcinoma of the cervix of the uterus.</b>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20c. TIME OF INJURY</b> Hour _____ e.m. _____ p.m. _____ Month, Day, Year _____ 19 _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____													
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JUNE 26, 1947</u> <b>to</b> <u>April 8, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>APRIL 8, 1961</u> <b>and that death occurred at</b> <u>5:30 P.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Alfred Cole</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>136 S. Hilton St., Balto. 29, Md.</u>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Alfred Cole, M.D.</u>				<b>22b. DATE SIGNED</b> <u>APRIL 8, 1961</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4/12/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Laurel Park</u>		<b>23d. LOCATION (City, town or county)</b> <u>Balto. 29, Md</u> <b>(State)</b> _____							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witke 4101 Edmondson Ave</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 12 '61</u>									
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Consecutive hours before  
Rheumatic heart disease with mitral stenosis

X Squamous cell carcinoma of the cervix of the uterus

June 22 47 April 2 41

April 8 41

Copy of

136 S. Wilson St., Safford, Ariz.

After Cole, ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND  
CERTIFICATE OF DEATH  
04035

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Randallstown</b>				c. LENGTH OF STAY IN 1b <b>2 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chapel Hill Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mrs.</b> Middle <b>Ida</b> Last <b>B. W. Roe</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 26, 1866</b>	
9. AGE (In years lost birthday) yrs. <b>94</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Williams</b>				14. MOTHER'S MAIDEN NAME <b>Annie Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Irene Roe, 6408 Walnut St. Balto. 7, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute bacterial pneumonia</b> DUE TO (c) <b>Generalized Arterio Sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arterio Sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>2 wks</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Generalized Arterio Sclerosis</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1957</b> to <b>April 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 12, 1961</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Earl L. Chambers</b>				22b. DATE SIGNED <b>4/13/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Chambers</b>				22d. ADDRESS <b>4108 Liberty Heights Ave. Balto. 7, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>				25a. REC'D BY REGISTRAR <b>APR 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4042

04036

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9 Gerard Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> d. STREET ADDRESS <b>9 Gerard Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Arthur I. Ropka</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>April 17, 1961</b> Month Day Year			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 23, 1887</b>	
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore Transit Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Henry Ropka</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mrs. Arthur I. Ropka-9 Gerard Avenue-Timonium</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RECTUM, METASTATIC</b> DUE TO (b) <b>154X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 YR</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF PROSTATE</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>NOV 11, 1960</b> to <b>APRIL 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>APR 11, 1961</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>William A. Pillsbury</b> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>4-17-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>WILLIAM A. PILLSBURY</b>				<b>22d. ADDRESS</b> <b>2060 YORK RD, TIMONIUM, MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>April 19, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Dulaney Valley Mem. Gardens</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John J. Schaefer</b>				<b>25a. REC'D BY REGISTRAR</b> <b>APR 18 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

82840

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Reg. Dist. No. **04037**

## MEDICAL CERTIFICATION

VS A1S (4)

4 hours after death.



James A. Smith - Deceased

James A. Smith - Deceased

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James A. Smith - Deceased



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4044

04038

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> <span style="float: right;">c. LENGTH OF STAY IN lb <b>7 Days</b></span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4031 Shannon Drive</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>GEORGE A. RUBY</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>12</b> Year <b>1961</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>June 21, 1922</b>		<b>9. AGE</b> (In years last birthday) <b>38 yrs.</b>		<b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months <b>Days</b> <b>Hours</b> <b>Min.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clothing Cutter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Clothing Factory</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Vincent McClellan Ruby</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Bennetta Cavanagh</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>214-18-9594</b>		<b>17. INFORMANT</b> <b>Clin. Records, VAH, Balto. Md. Ft. Howard Div.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one causa par linea for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b> DUE TO (b) <b>AZOTEMIA DUE TO A.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>		<b>21. I certify that</b> <b>X</b> (this hospital) attended the deceased from <b>April 5, 1961, to April 12, 1961, that</b> <b>X</b> (we) last saw the deceased alive on <b>April 5, 1961, and that death occurred at</b> <b>5:40AM</b> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> 		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <b>4/12/61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>THOMAS F. CRAHAN, M. D.</b>			
<b>22d. ADDRESS</b> <b>VAH, Baltimore, Md. Ft. Howard Div.</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>4/15/61</b>					
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. John's Lutheran Cemetery</b> <b>23d. LOCATION (City, town or county)</b> <b>Baltimore, Maryland</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck</b> <b>ADDRESS</b> <b>5305 Harford Rd. Baltimore, Maryland</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>APR 14 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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George Washington Hospital  
Johns Hopkins Hospital  
Maryland  
Washington, D.C.  
U.S.A.  
George Washington Hospital  
Johns Hopkins Hospital  
Maryland  
Washington, D.C.  
U.S.A.  
George Washington Hospital  
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Washington, D.C.  
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George Washington Hospital  
Johns Hopkins Hospital  
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4045

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04039

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>Washington, D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D. C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Joseph's Nursing Home</b>		d. STREET ADDRESS <b>2311 Connecticut Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maria</b> Middle <b>Rucinska</b> Last <b>Rucinska</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>	
13. FATHER'S NAME <b>Joseph Harabianko</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Zukowska</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Joseph Rucinski 2311 Connecticut Ave. N. W.</b>		18. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Generalized Arteriosclerosis with</b> DUE TO (c) <b>gangrene right leg.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4/10/61 - 4/12/61</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Impending gangrene and gangrene of right leg of 4 wks.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/11/61</b> 19 to <b>4/11/61</b> 19, that (I) (we) last saw the deceased alive on <b>4/9/61</b> 19, and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>B. Martin Middleton</b>		22b. DATE SIGNED <b>4/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. Martin Middleton M. D.</b>		22d. ADDRESS <b>614 Medical Dpts Baltol, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town, or county) (State) <b>Silver Spring, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE APR 19 '61</b>	
ADDRESS <b>Catonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hanna</b>	

MEDICAL CERTIFICATION

04039

CERTIFICATE OF DEATH

1944

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DEPARTMENT OF HEALTH  
BUREAU OF STATISTICS  
CENTRAL OFFICE OF DEATH

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital		d. STREET ADDRESS 11414 CHAPEL HILL DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY		Middle MAX		Last SAUERS		4. DATE OF DEATH Month 4	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/27/28	
9. AGE (In years lost birthday) 32 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME HENRY SAUERS		14. MOTHER'S MAIDEN NAME HELEN POPIACKI					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.I.A.R.F. 219-22-9625		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS FAR ADVANCED</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 4-10-1961 to 4-18-1961, that (we) last saw the deceased alive on 4-18-1961, and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/18/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-22-1961		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town, or county) (State) Parkville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 2401 Belair Road		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

NAME OF DECEASED  
M. W. 2/1/24

NAME OF DECEASED  
M. W. 2/1/24

NAME OF DECEASED  
M. W. 2/1/24

NAME OF DECEASED  
M. W. 2/1/24

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04042

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Brooklyn Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines Conv. Home</b>		d. STREET ADDRESS <b>121 W. Meadow Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Santa</b> Middle <b>Scalie</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 13, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>Michael Balsame</b>		14. MOTHER'S MAIDEN NAME <b>Frances Scalie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Frances D'Alfonzo</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO <b>Arteriosclerotic C.V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1958</b> to <b>April 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>4/24</b> 1961, and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Vincent M. Messina</b>		22b. DATE <b>April 26, '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Vincent M. Messina M.D.</b>		22d. ADDRESS <b>1403 S. Charles St. Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick Rd. Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gence</b>		25a. REC'D BY REGISTRAR <b>4001 Ritchie Hwy. A. A. Co</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>		DATE <b>MAY 1 '61</b>	

1945

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		Jan. 10, 1945	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Place of Birth		New York City	
Cause of Death		Heart Disease	
Place of Death		New York City	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		Jan. 15, 1945	
Place of Registration		New York City	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4043

## CERTIFICATE OF DEATH

04043

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3601 Lochearn Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u> d. STREET ADDRESS <u>3601 Lochearn Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>George F. Scherer</u>		<b>4. DATE OF DEATH</b> <u>April 21, 1961</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 7, 1875</u>		<b>9. AGE</b> (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Conrad-Hamp Company</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>August Scherer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sophia ?</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <u>212-03-9565</u>				<b>17. INFORMANT</b> <u>Mr. George M. Scherer</u>				<b>Address</b> <u>3601 Lochearn Drive</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>AS&amp;D</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>minutes</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>Acute &amp; Chr. Diverticulitis, Colon</u>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Sept 25, 1959</u> to <u>April 21, 1961</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Aug 20, 1961</u> , and that death occurred at <u>  </u> M., from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Daniel Bakal</u>				<b>22b. DATE SIGNED</b> <u>  </u>				<b>22c. PHYSICIAN'S NAME</b> (Type) <u>DANIEL BAKAL</u>			
<b>22d. ADDRESS</b> <u>3600 Lochearn Dr. - 7</u>				<b>22e. M.D.</b> <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.				<b>22f. DATE</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4-24-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Woodlawn, Maryland</u>		<b>(State)</b>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 24 '61</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm J. Lickner &amp; Sons</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm J. Lickner</u>				<b>25c. DATE</b> <u>APR 24 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01043

01043

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Handwritten notes and signatures at the bottom of the page, including the name "JAMES EARL RAY" and other illegible text.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04044

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 4 1/2 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore d. STREET ADDRESS 108 N. Prospect Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT WILLIAM SCHLERF				4. DATE OF DEATH Month Day Year 4 21 1961											
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-1908		9. AGE (In years lost birthday) yrs. 52		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHRISTIAN SCHLERF				14. MOTHER'S MAIDEN NAME AMANDA (?)											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. No				17. INFORMANT Hospital Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Far advanced pulmonary tuberculosis DUE TO (b) 6 years Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of lung 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 12-6-1960 to 4-21-1961, that (I) (we) last saw the deceased alive on 4-21-1961, and that death occurred at 3:35 PM from the causes and on the date stated above.															
22a. SIGNATURE Wm. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 4-21-1961											
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-24-1961		23c. NAME OF CEMETERY OR CREMATORY London Park				23d. LOCATION (City, town, or county) (State) Baltimore - Md					
24. FUNERAL DIRECTOR'S SIGNATURE Mac Harrison				ADDRESS Catonsville - 28-Md				25a. REC'D BY REGISTRAR DATE APR 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

05058

CERTIFICATE OF MARRIAGE

05058

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12 10 41

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4051

04045

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <b>Towson</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Armacoast Nursing Home</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>6700 Parkway Rd. 12</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>FRIEDA H. SCHNEIDER</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>20</b> Year <b>1961</b>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months <b>7</b> Days <b>7</b> IF UNDER 24 HRS.: Hours <b>7</b> Min. <b>7</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Aug. 5, 1883</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Nursing</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Germany</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>					
<b>13. FATHER'S NAME</b> <b>Ludwig Hoffman</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Viola Collier- 6700 Parkway Rd 12</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> (b) <b>Hypertensive Cardiovascular</b> (c) <b>Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 Days</b> <b>10 y</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>17 April 1961</b> <b>to</b> <b>20 April 1961</b> ; that (I) (we) last saw the deceased alive on <b>19 April 1961</b> , and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Charles O'Donnell</b> M.D.				<b>22b. DATE SIGNED</b> <b>APR 24 '61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/ 22/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ivy Hill</b>			
<b>23d. LOCATION</b> (City, town or county) <b>(State)</b> <b>Laurel, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

01045

01045

Baltimore

Baltimore

Baltimore



Towson

Towson

6703 Parkway Rd. 12

6703 Parkway Rd. 12

April 20, 1961

April 20, 1961

April 20, 1961

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USA

Germany

Germany

Germany

Unknown

Unknown



6703 Parkway Rd. 12

6703 Parkway Rd. 12

6703 Parkway Rd. 12

*Handwritten signature and notes, mostly illegible.*

*Handwritten signature and notes, mostly illegible.*

Division, Maryland

Division, Maryland

Division, Maryland

Division, Maryland

6703 Parkway Rd. 12, Towson, Md. 21204

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4052 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04046											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
c. LENGTH OF STAY in 1b <b>Life</b>						d. STREET ADDRESS <b>8921 Grove Road</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8921 Grove Road</b>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JOHN BENJAMIN SCHRENKER</b>						4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-12-1889</b>		9. AGE (in years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>				11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John B. Schrenker</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Braun</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edward B. Schrenker 3807 Putty Hill Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						DATE SIGNED <b>4/28/61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-1-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or country) (State) <b>Parkville Md.</b>			
23. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>						24a. REC'D BY REGISTRAR <b>MAY 1 1961</b>					
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>					

041138

DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

8821 Grove Road

8821 Grove Road

April 27 1961

April 27 1961

DECEASED

DECEASED

JOHN

White

Male

Arteriosclerotic Cardiovascular Disease

Arteriosclerotic Cardiovascular Disease

Heart

Arteriosclerotic Cardiovascular Disease

Arteriosclerotic Cardiovascular Disease

Arteriosclerotic Cardiovascular Disease

Arteriosclerotic Cardiovascular Disease

Arteriosclerotic Cardiovascular Disease

Arteriosclerotic Cardiovascular Disease

Arteriosclerotic Cardiovascular Disease

Charles S. Potts, M.D.

1961





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4053

CERTIFICATE OF DEATH

Reg. Dist. No. 04047

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Rd.</u>				d. STREET ADDRESS <u>Belair Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Henry</u> Middle <u>Schroeder</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1877</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Augustus Schroeder</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Roeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mary E. Schroeder</u> Address <u>Belair Rd. Perry Hall Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ce Prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>61</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city or town, state) <u>Mingsville, Md</u> DATE SIGNED <u>4-29-61</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Perry Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Caroline Lunnal Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 3 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4054

4054

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04048

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OVERLEA</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7505 BELAIR RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>CATHERINE</b> Last <b>SCHULER</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-30-1906</b>	
9. AGE (In years lost birthday) <b>54</b> yrs.		10. AGE (In years lost birthday) <b>54</b> yrs.		11. AGE (In years lost birthday) <b>54</b> yrs.		12. AGE (In years lost birthday) <b>54</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RESTAURANT OWNER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ERNST BEHNCKEN</b>				14. MOTHER'S MAIDEN NAME <b>MARIE DENGLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>219-32-0592</b>		17. INFORMANT <b>DAVID SCHULER 7505 BELAIR RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma - Lungs and Bone</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of breast - left 1952 - right 1959</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>- 9 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>BALTO., MD</b>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1952</b> , to <b>April 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1961</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles V. Sevcik</b>				22b. DATE <b>4/11/61</b>		22c. SIGNATURE <b>Charles V. Sevcik</b>	
22d. PHYSICIAN'S NAME (Type) <b>Charles V. Sevcik</b>				22e. ADDRESS <b>5101 Belair Rd Baltimore, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>4-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>	
23d. LOCATION (City, town, or county) <b>BALTO., MD</b>				23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lessahn Jun Hwang</b>				24a. ADDRESS <b>7401 Belair Rd.</b>		24b. REC'D BY REGISTRAR <b>APR 14 '61</b>	
24c. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>				24d. DATE <b>APR 14 '61</b>			

05028

MINISTRY OF HEALTH  
CERTIFICATE OF DEATH

1934

(M)

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4055 CERTIFICATE OF DEATH 04049											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>						c. LENGTH OF STAY IN 1b <b>15 yrs.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Training School</b>						d. STREET ADDRESS <b>1420 Reynolds Street</b>					
3. NAME OF DECEASED (Type or print) <b>Christine Helen Shade</b>						4. DATE OF DEATH Month <b>4</b> Day <b>14</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/10/31</b>		9. AGE (In years last birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dependent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Gabriel Shade</b>						14. MOTHER'S MAIDEN NAME <b>Eleanor Watkins</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>none</b>					
17. INFORMANT <b>Rosewood Records</b>						Address <b>Owings Mills, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONITIS</b> 351X DUE TO (b) <b>SPASTIC DIPLEGIA.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/27</b> , 19 <b>61</b> , to <b>4/14</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/14</b> , 19 <b>61</b> , and that death occurred at <b>9:45 a.m.</b> the causes and on the date stated above.											
22a. SIGNATURE <b>Ernest I. Decko</b> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>4/14/61</b> 22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>Ernest I. Decko, M.D.</b>						22d. ADDRESS <b>Rosewood St. Tr. School, Owings Mills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4-18-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>		23d. LOCATION (City, town or county) (State) <b>Balto 25</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>McCurly Funeral W 130 E Fort Ave JNW</b>						25a. REC'D BY REGISTRAR <b>APR 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

02040

(M)

(1)

THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D. C. 20315



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be filled with the information required by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4056

CERTIFICATE OF DEATH

Reg. Dist. No.

04050

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6807 Linden Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Francis Marion Shane Sr.</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Archer Shane</u>	
14. MOTHER'S MAIDEN NAME <u>Mollie Poiner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mary V. Shane</u> Address <u>6807 Linden Ave. (6)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Other selective Cardiovascular Dis</u> (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>inst</u> <u>yes</u> <u>unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>4-5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-23</u> , 19 <u>61</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>John C. Hyle</u> M.D. <u>7527 Belair Rd</u> DATE SIGNED <u>4-5-61</u> PHYSICIAN'S NAME (Type) <u>JOHN C. HYLE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-8-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Essau Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '61</u>	
ADDRESS <u>7401 Belair Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1956

01050

(M)

NAME: *John C. Smith*  
AGE: *78*  
SEX: *M*  
DATE OF BIRTH: *1901*  
PLACE OF BIRTH: *St. Louis, Mo.*  
OCCUPATION: *Retired*  
CAUSE OF DEATH: *Heart Disease*  
DATE OF DEATH: *1956*  
PLACE OF DEATH: *St. Louis, Mo.*  
SIGNATURE: *John C. Smith*  
WITNESSES: *John C. Smith*  
*John C. Smith*  
*John C. Smith*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4057

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04051

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Freeland Rd.</u>		d. STREET ADDRESS <u>Freeland Rd. 1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Wilbur Shelley</u> First Middle Last		4. DATE OF DEATH <u>April 7 1961</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joshua M. Shelley</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca J. Hackett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. John S. Swanger, Freeland Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4/7/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 10, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein, New Freedom, Pa.</u>		ADDRESS	
24b. REC'D BY REGISTRAR <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>APR 10 '61</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

4058

4058

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04052

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>3 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elias</b> Middle <b>John</b> Last <b>Shepperd</b>		4. DATE OF DEATH Month <b>4</b> Day <b>29</b> Year <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-7-1883</b>
9. AGE (In years last birthday) <b>78</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>29</b> Hours <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. Rail Road</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.A</b>	
13. FATHER'S NAME <b>John Shepperd</b>		14. MOTHER'S MAIDEN NAME <b>Ida Bacon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>A. John Geyer</b>		Address <b>330 Regester Ave. #12</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> <b>Ischemic Cardio Vascular Disease</b> DUE TO <b>Arteriosclerosis &amp; Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>Jan 20, 1959</b> to <b>April 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 27, 1961</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Laurence C. Post</b>		22b. DATE SIGNED <b>4/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>		22d. ADDRESS <b>6805 York Rd Baltimore 12 Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-29-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. James My Ladys Manor</b>		23d. LOCATION (City, town, or county) (State) <b>Monkton, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Serviced Towson 4, Md</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

CERTIFICATE OF DEATH

1957

1

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

4059  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04053

1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Raspeburg</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4913 Kenwood Avenue</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Raspeburg</b> d. STREET ADDRESS <b>4913 Kenwood Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>DEBORAH</b> Middle <b>LEE</b> Last <b>SIPPEL</b>			4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 61</b>		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>April 28, 1958</b>		
9. AGE (In years last birthday) <b>2</b> yrs.			IF UNDER 1 YEAR Months <b>11</b> Days <b>9</b>		
IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			13. FATHER'S NAME <b>John E. Sippel</b>		
14. MOTHER'S MAIDEN NAME <b>Mary R. Doyle</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>John E. Sippel</b> Address <b>4913 Kenwood Ave. (6)</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial Pneumonitis.</b> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/7/61</b>					
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-11-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>	
22d. LOCATION (City, town, or country) (State) <b>Trupp Mill Rd. Balto. Co. Md.</b>		23. FUNERAL DIRECTOR ADDRESS <b>Lisach Funeral Home 7401 Belair Rd.</b>			
24a. REC'D BY REGISTRAR DATE <b>APR 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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April 1, 1938

STREET

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WISCONSIN

2

April 1, 1938

White

Female

( )

Infant of unknown

2

X \_\_\_\_\_

X \_\_\_\_\_

10/1/38

Charles E. Peck, M.D.

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M  
4060  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04054

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. LENGTH OF STAY IN 1b <b>3 yrs 11 mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>19 Roguel Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BARBARA</b> Middle <b>ANNE</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/1875</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Isaac T. Bewley</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Kaser</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Margaret Stergleman daughter</b> Address <b>1330 N. Hollenback Blvd. #28</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 422.1 DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Chronic Brain Syndrome Assoc. e Arteriosclerosis</b> DUE TO (c) <b>Chronic Brain Syndrome Assoc. e Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Assoc. e Arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 23 1957</b> to <b>April 21 1961</b> , that (I) (we) last saw the deceased alive on <b>April 21 1961</b> , and that death occurred at <b>11:00 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Jose R. Arizaga</b>				22b. DATE SIGNED <b>4/21/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOSE R. ARIZAGA</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/25/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL BALTIMORE, MD.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Funeral Home Catonsville</b>				25a. REC'D BY REGISTRAR <b>md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kiser</b>	

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114008

CERTIFICATE OF DEATH

114008

(M)

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF BIRTH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04055

1  
FOR STATE  
HEALTH DEPT.  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9648 Dixon Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>9648 Dixon Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. David Arthur Smith</u> First Middle Last 4. DATE OF DEATH <u>April 10th 19 61</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct 30, 1900</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bendix Company</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John W. Smith</u> 14. MOTHER'S MAIDEN NAME <u>Ida ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Edith B. Smith</u> Address <u>same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/10/61</u> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4/13/61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>		23. FUNERAL DIRECTOR <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u> 24a. REC'D BY REGISTRAR <u>APR 11 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krawe</u>	



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02020

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF EXAMINER

DATE OF SIGNATURE

PLACE OF SIGNATURE

OFFICE OF THE MEDICAL EXAMINER

CITY OF NEW YORK

STATE OF NEW YORK

COUNTY OF NEW YORK

TOWNSHIP OF NEW YORK

WARD OF NEW YORK

PRECEDENT OF NEW YORK

SUCCESSOR OF NEW YORK

PREDECESSOR OF NEW YORK

SUCCESSOR OF NEW YORK

PREDECESSOR OF NEW YORK

SUCCESSOR OF NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4062											
CERTIFICATE OF DEATH											
04056											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN lb <u>2 WEEKS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RIDGEWAY NURSING HOME</u>						d. STREET ADDRESS <u>607 DENNISON ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Joseph Smith</u>						4. DATE OF DEATH Month <u>APRIL</u> Day <u>6</u> Year <u>1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 27, 1883</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FUNERAL DIRECTORS ASS'T</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MUNERAL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George J. Smith</u>						14. MOTHER'S MAIDEN NAME <u>SARAH JANE EASTERLEY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HELEN FREEMAN</u>		Address <u>607 DENNISON ST.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO</u> <u>VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>422</u> (c) <u>422</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> 19 <u>61</u> to <u>4/6</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>61</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Thos E Roach</u>						22b. DATE SIGNED <u>4/6/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Thos E Roach</u>						22d. ADDRESS <u>3629 Edmondson Ave Bkto-29-M</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-8-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City, town or county) <u>BALTIMORE, MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Miller</u>						25a. REC'D BY REGISTRAR <u>APR 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

DATE 11/1/01 BY SP-6 [illegible]  
REASON: [illegible]

APPROVED FOR RELEASE BY NSA/CSS

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4063

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G285 4/20/61 iwk

Reg. Dist. No. 04057

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Martin Company</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>R.</u> Middle <u>Smith</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>12th</u> Year <u>19 61</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 20, 1911</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>The Martin Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Smith</u>				14. MOTHER'S MAIDEN NAME <u>Bessie/ Bertha unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-01-6179</u>			
				17. INFORMANT <u>Mrs. Lida C. Smith</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C. Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>APR 14 61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OVERLEA</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4811 KENWOOD AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>SMITH</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 6, 1902</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES ROBE.</b>		14. MOTHER'S MAIDEN NAME <b>HAUNAN NIEMEYER.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-28-0358</b>	
17. INFORMANT <b>HERMAN P SMITH</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artero-sclerotic cardio-vascular disease</b> DUE TO (c) <b>years.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis, severe</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/24</b> 19 <b>61</b> , to <b>4/26</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4/24</b> 19 <b>61</b> , and that death occurred at <b>A</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>4/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. J. Samuels, M.D.</b>		22d. ADDRESS <b>Franklin Square Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>APRIL 29, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEM.</b>	23d. LOCATION (City, town, or county) (State) <b>PARKVILLE MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jessie Funeral Home 7401 Belair Rd #6</b>		25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No. 04059

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>269 COLGATE AVE.</u>		d. STREET ADDRESS <u>269 COLGATE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES EDWARD</u> First <u>SPALDING</u> Middle <u>J</u> Last		4. DATE OF DEATH <u>April</u> Month <u>1</u> Day <u>1961</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 13, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AMOS SPALDING</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN CONRAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>099-05-4057A</u>	
17. INFORMANT <u>MRS. JESSIE KURTZ</u>		Address <u>269 COLGATE AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of Left Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to Brain</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>17 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>59</u> , to <u>April</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 31</u> , 19 <u>61</u> , and that death occurred at <u>11:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Mrs. M. S.</u>		ADDRESS (Street, city or town, state) <u>6800 Mornington - 4/3/61</u>	
PHYSICIAN'S NAME (Type) <u>Dundalk - Dr. M. S.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL APR. 4, 1961</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PARKVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME, DUNDALK, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

Page 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4066

04060

3201-4

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>7 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
				f. STREET ADDRESS <b>325 Winston Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>(S.A. JOHN A. SPEAR)</b>				4. DATE OF DEATH Month Day Year <b>April 25 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 2, 1893</b>	
9. AGE (in years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Company</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John R. Spear</b>				14. MOTHER'S MAIDEN NAME <b>Lillian E. Unduch</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>216-05-1203</b>			
17. INFORMATION <b>VAH, BALTIMORE 18, MARYLAND, Ft. Howard Division</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HEART FAILURE</b>							<b>5 MINUTES</b>
DUE TO (b) <b>DELERIUM TREMENS</b>							<b>7 DAYS</b>
DUE TO (c) <b>CHRONIC ALCOHOLISM</b>							<b>MANY YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>Corneal Ulceration, Right Eye</b>							
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>April 18 1961</b> to <b>April 25 1961</b> , that (b) (we) last saw the deceased alive on <b>April 25 1961</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Daniel R. Zoll</b>				22b. DATE SIGNED <b>4-25-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>DANIEL R. ZOLL</b>				22d. ADDRESS <b>VAH Baltimore Md - Ft Howard Division</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-28-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Seitz Funeral Home</b>				25a. REC'D BY REGISTRAR <b>MAY 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

Seitz & Seitz

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Figure 1. Study design.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4067

04061

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10 Rusting Avenue</u> <u>House in the Pines Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>1817 Fairview Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Anna</u> Middle <u>R.</u> Last <u>Spitzer</u>			<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>27</u> , Year <u>1961</u>				
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Nov. 4, 1874</u>			
<b>9. AGE</b> (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Germany</u>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>XXXXXX Germany</u>			<b>13. FATHER'S NAME</b> <u>Unknown</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				
<b>16. SOCIAL SECURITY NO.</b> <u>none</u>			<b>17. INFORMANT</b> Address <u>Mrs. Wm. B. Mc Closkey-6306 Mossway Balto. 12</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1530</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-30-1949</u> <b>to</b> <u>4-27-1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>4-25-1961</u> , <b>and that death occurred at</b> <u>245 PM</u> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Wilmer K. Gallagher</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Wilmer K. Gallagher M.D.</u>			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>6209 Frederick Rd., Baltimore 28, Md.</u>				
<b>22b. DATE SIGNED</b> <u>4-28-61</u>			 				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>4-29-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Maryland</u> <b>(State)</b> _____		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>North Anna Home</u> <u>Baltimore 17, Md.</u>					
<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAY 1 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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Bellevue, Maryland

London, England

1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4663  
CERTIFICATE OF DEATH

04062

1. PLACE OF DEATH a. COUNTY <b>BALTO.,</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>STEMMERS RUN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>542 STEMMERS RUN ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>SPONHEIMER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-1905</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICE LUIET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ERNEST SPONHEIMER</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE WIEGAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. ANNA E. SPONHEIMER</b>		Address <b>542 STEMMERS RUN RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>Carcinoma of Larynx</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>161X</b> (c) <b>3 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1961</b> , to <b>April 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 9, 1961</b> , and that death occurred at <b>4:11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Gardner</b>		22b. DATE SIGNED <b>4/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Gardner</b>		22d. ADDRESS <b>Balto 6 Ind.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-13-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ZION LUTH. CEM</b>		23d. LOCATION (City, town, or county) (State) <b>STEMMERS RUN MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Fun'l Home</b>		25a. REC'D BY REGISTRAR <b>APR 13 '61</b>	
ADDRESS <b>7401 Belwin Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

1900

10183



Form with multiple lines for text entry, including fields for name, age, sex, date of death, and cause of death. The text is faint and mostly illegible.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
4063											
04063											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Govans Woodbrook</b> c. LENGTH OF STAY in 1b <b>Woodbrook Lane</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Woodbrook Lane</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Govans Woodbrook</b> d. STREET ADDRESS <b>Woodbrook Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>MARIE</b> Last <b>SPRUELS</b>						4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 6, 1901</b>		9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>59</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own-home</b>				11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Daly</b>						14. MOTHER'S MAIDEN NAME <b>Norah Fanning</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b> (If yes give year or dates of service) <b>none</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Family records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barbiturate Intoxication</b> 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>970.2</b> (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>970.2</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingestion of Barbiturates.</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>XXXX 4/25/19 61</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Woodbrook</b>		20g. (County) <b>Balto.</b>	
20h. (State) <b>Md.</b>											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>4/25/61</b>											
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. <b>Charles S. Petty, M.D.</b>		Address (Street, city, town, or county) <b>Baltimore</b>		DATE SIGNED <b>4/25/61</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/28/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or country) <b>Baltimore</b>		22e. (State) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>John Burns Son's</b>						ADDRESS <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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Post Holy Redeemer Cemetery

Littleton

16

Charles S. Gentry

1/28/61

Post Holy Redeemer Cemetery

Littleton

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Post Holy Redeemer Cemetery

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Post Holy Redeemer Cemetery

Littleton

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **04064**

**4070**

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	c. LENGTH OF STAY IN 1b <b>2 years.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at her home.</b>		d. STREET ADDRESS <b>305 Eastern Blvd.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROSELIA</b> Middle <b>VICTORIA</b> Last <b>STABLER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March-20-1911</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Michael Takacs</b>	
14. MOTHER'S MAIDEN NAME <b>Ida Phillips</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>261-60-1530</b>		17. INFORMANT <b>Mr. A. Earl Stabler (husband)</b> Address <b>305 Eastern Blvd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Bronchial Pneumonia</b> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Operations Intestinal Obstruction</b> DUE TO (c) <b>Peritonitis Ruptured Stomach Ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 year</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 14, 1961</b> to <b>April 15, 1961</b> , that I last saw the deceased alive on <b>April 15, 1961</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. M. Baumgardner</b>		ADDRESS (Street, city or town, state) <b>Balto 6 Md</b>	
PHYSICIAN'S NAME (Type) <b>S. M. Baumgardner</b>		DATE SIGNED <b>4/16/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>April-18-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart &amp; Mowen Co., 108-W-North-Av. Balto. 1-Md</b>		24a. REC'D BY REGISTRAR <b>DATE APR 17 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



WAR AND STATE DEPARTMENT OF HEALTH—BIRMINGHAM 13



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Page 1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04065

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>10 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>5917 BURGESS AVE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>STANLEY</b> Last <b>—</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-1871</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>MARTIN KRAFT</b>		14. MOTHER'S MAIDEN NAME <b>PAULINE STENGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Paul L. Smith Jr.</b> Address <b>Cockeysville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Cardiac Vascular Accident</b> DUE TO <b>Hypertensive Arterio Sclerotic Cardio</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Vascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-21</b> 19 <b>61</b> , to <b>4-21</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>4-21</b> 19 <b>61</b> , and that death occurred at <b>4:40 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>4/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>		22d. ADDRESS <b>COCKEYSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 26, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>		25a. REC'D BY REGISTRAR <b>APR 25 '61</b>	
ADDRESS <b>1217 St. Paul Street</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Friend</b>	

05000

CERTIFICATE OF DEATH

1171

M

1

1901, 10, 10

1901, 10, 10



100000

(M)

(1)

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

may be retained by the hospital, attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1d, Film G284 4/7/61 1wk

## CERTIFICATE OF DEATH

Reg. Dist. No.

04067

<p>1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u></p>				<p>c. LENGTH OF STAY IN 1b <u>21 mo</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Women &amp; Aged Men's Home</u> <u>615 Chestnut Ave. Towson 4, Md.</u></p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>E.</u> Last <u>STOLZENBACH</u></p>				<p>4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1961</u></p>			
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>W.</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>July 29, 1867</u></p>	
<p>9. AGE (In years last birthday) <u>93</u> yrs.</p>		<p>IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.</p>		<p>IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROGER</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROGER</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>BALTIMORE</u></p>	
<p>13. FATHER'S NAME <u>ECKHART STOLZENBACH</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>ANNA WIEGAND</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p>				<p>16. SOCIAL SECURITY NO. <u>213-226012</u></p>			
<p>17. INFORMANT <u>DAISY E. HAMILTON, R.N. 615 Chestnut Ave. Towson</u></p>				<p>Address</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio-renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>18 mo</u> DUE TO (c)</p>						<p>INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cholelithiasis and Cholelithiasis?</u></p>						<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>BALTIMORE</u></p>	
<p>20f. (City or town) <u>BALTIMORE</u></p>				<p>(County) (State)</p>			
<p>21. I certify that I attended the deceased from <u>1957</u> to <u>April 1</u>, 19<u>61</u>, that I last saw the deceased alive on <u>March 30</u>, 19<u>61</u>, and that death occurred at <u>2:30</u> PM, from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE <u>Howard Edmond Day</u> M.D.</p>				<p>ADDRESS (Street, city or town, state) <u>4 E-33rd St Balto 18 April 1961</u></p>			
<p>DATE SIGNED <u>APR 4 '61</u></p>				<p>24b. REGISTRAR'S SIGNATURE <u>William L. Frank</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>22b. DATE THEREOF <u>4-4-61</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred. A. Cole</u></p>				<p>ADDRESS <u>1913 W. Balto. St.</u></p>			



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>William Charles Fisher</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 15, 1941</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. PLACE OF BIRTH <i>Baltimore, Md.</i>		14. DATE OF BIRTH <i>March 10, 1896</i>		15. OCCUPATION <i>Engineer</i>	
16. MARITAL STATUS <i>Married</i>		17. NAME OF SPOUSE <i>Elizabeth Fisher</i>		18. NAME OF CHILDREN <i>John, Mary, Robert</i>	
19. NAME OF FUNERAL HOME <i>Smith &amp; Sons</i>		20. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		21. NAME OF MINISTER <i>Rev. J. K. Brown</i>	
22. NAME OF CLERGYMAN <i>Rev. J. K. Brown</i>		23. NAME OF CHURCH <i>St. Paul's Episcopal</i>		24. NAME OF CEMETERY <i>Greenwood</i>	
25. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>		26. NAME OF MINISTER <i>Rev. J. K. Brown</i>		27. NAME OF CLERGYMAN <i>Rev. J. K. Brown</i>	
28. NAME OF CHURCH <i>St. Paul's Episcopal</i>		29. NAME OF CEMETERY <i>Greenwood</i>		30. NAME OF BURIAL PLACE <i>Greenwood Cemetery</i>	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 APR 15 1941  
 WILLIAM CHARLES FISHER  
 BALTIMORE, MARYLAND  
 DECEASED  
 APRIL 15, 1941  
 CAUSE OF DEATH  
 MYOCARDIAL INFARCTION  
 DISEASE OR INJURY  
 CORONARY ARTERY DISEASE  
 MANNER OF DEATH  
 NATURAL  
 SIGNATURE OF PHYSICIAN  
 DR. J. H. SMITH  
 SIGNATURE OF REGISTRAR  
 JOHN DOE  
 SIGNATURE OF WITNESS  
 JOHN DOE  
 PLACE OF BIRTH  
 BALTIMORE, MD.  
 DATE OF BIRTH  
 MARCH 10, 1896  
 OCCUPATION  
 ENGINEER  
 MARITAL STATUS  
 MARRIED  
 NAME OF SPOUSE  
 ELIZABETH FISHER  
 NAME OF CHILDREN  
 JOHN, MARY, ROBERT  
 NAME OF FUNERAL HOME  
 SMITH & SONS  
 NAME OF BURIAL PLACE  
 GREENWOOD CEMETERY  
 NAME OF MINISTER  
 REV. J. K. BROWN  
 NAME OF CLERGYMAN  
 REV. J. K. BROWN  
 NAME OF CHURCH  
 ST. PAUL'S EPISCOPAL  
 NAME OF CEMETERY  
 GREENWOOD  
 NAME OF BURIAL PLACE  
 GREENWOOD CEMETERY



Reg. Dist. No. 04068

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LONG GREEN</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 KANE ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First <u>ADELIA</u> Middle <u>STREETT</u> Last		4. DATE OF DEATH <u>APRIL</u> Month <u>16</u> Day <u>1961</u> Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 22 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WHITE FORD MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HUGH C. WHITE FORD</u>		14. MOTHER'S MAIDEN NAME <u>PHOEBE FLA HARTY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Arteriosclerotic CVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-14</u> , 19 <u>61</u> , and that death occurred at <u>11:35</u> A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>4-17-61</u>			
ACTUAL SIGNATURE <u>William A. Tyson</u>		M.D. <u>Kingsville, Md.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/19/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WILLIAM WATTERS</u>		22d. LOCATION (City, town, or county) (State) <u>COOPTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Hunt</u>		ADDRESS <u>Farmingtonville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 19 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

## MEDICAL CERTIFICATION

**I**

CERTIFICATE OF DEATH

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4075

## CERTIFICATE OF DEATH

04069

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CH</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u> d. STREET ADDRESS <u>305 Oakley Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Clarence Donald Sullivan</u>		<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>5</u> Year <u>19 61</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9/29/16</u>
<b>9. AGE</b> (In years last birthday) <u>44</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Dependent</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore City, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Clarence Paola Sullivan (deceased)</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Bertie Estelle McCullough (deceased)</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>---</u>	
<b>17. INFORMANT</b> <u>Rosewood Records, Owings Mills, Md.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute meningitis</u> DUE TO (b) <u>Acute bronchopneumonia with abscesses</u> DUE TO (c) <u>abscesses</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>491X</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>20g. (County)</b>	
<b>20h. (State)</b>		<b>21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., and the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>W. Rieckert</u>		<b>22b. DATE SIGNED</b> <u>4-5-61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. Rieckert</u>		<b>22d. ADDRESS</b> <u>4307 Monfield Ave, Balto 14</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>4/8/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION (City, town or county)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Paul E. Charonoff, Jr.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>APR 7 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>25c. ADDRESS</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required.

IG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required.

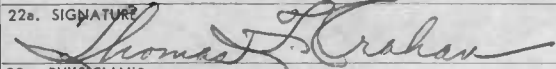
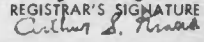
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4076

04070

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> <span style="float: right;">62 Days</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3222 Tioga Parkway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>ESTEBAN S. TAGUIBOLOS</b>				<b>4. DATE OF DEATH</b> <b>APRIL 17 19 61</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11/22/96</b>			
<b>9. AGE</b> (In years last birthday) <b>64</b> yrs.		<b>10. KIND OF BUSINESS OR INDUSTRY</b> <b>Fireman &amp; Water Tender Railroad</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Phillipine Islands...</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Antonio Taguibolos</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Simplicio Bagcion</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>217-14-2731</b>					
<b>17. INFORMANT</b> <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Division</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CONGESTIVE HEART FAILURE</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MYOCARDIAL SCARRING, NEPHROSCLEROSIS, ARTERIO-SCLEROTIC</b>				INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>  <b>RECENT</b>  <b>UNKNOWN</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/14/1961</b> to <b>4/17/1961</b> that <b>17</b> (we) last saw the deceased alive on <b>April 17, 1961</b> , and that death occurred at <b>4:40 AM</b> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> 				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>4/17/61</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Thomas F. Crahan, M.D.</b>				<b>22d. ADDRESS</b> <b>VAH, Balto. Md. Fort Howard Division</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4-20-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Baltimore, Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Elroy Wilson Funeral Home, Baltimore, Maryland</b>				<b>25a. REC'D BY REGISTRAR</b> <b>MAY 1 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 			

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Elroy Wilson General Home, Baltimore, Maryland

Thomas E. Graham, M.D.,  
Van Balto. Md. Port Howard Division

April 17 62  
Elroy Wilson

WILLIAM B. BROWN, JR., M.D., BALTIMORE, MARYLAND

ANTHONY J. BROWN, M.D., BALTIMORE, MARYLAND

CONVENTION OF THE BALTIMORE

BALTIMORE HOSPITAL

21-22-23 1962, Van Balto. Md. Port Howard Division

Atlanta, Georgia

Frederick Water Tower, Baltimore

Philadelphia, Pennsylvania

White, Baltimore, Maryland

8. 11/23/62

EMERSON

17

Veterans Administration Hospital, Baltimore

Port Howard, Baltimore

Baltimore

Baltimore



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
4077 CERTIFICATE OF DEATH 04071														
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenspring Avenue, RFD #1</u>					d. STREET ADDRESS <u>Greenspring Avenue, RFD #1</u>									
3. NAME OF DECEASED (Type or print) <u>Mrs. Naomi A. Tanner</u>					4. DATE OF DEATH <u>April 3, 1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 24, 1898</u>		9. AGE (In years to birthday) <u>63</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
13. FATHER'S NAME <u>Simeon Van Trump</u>					14. MOTHER'S MAIDEN NAME <u>Jennie Trout</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)					16. SOCIAL SECURITY NO. <u>217-22-8725</u>					17. INFORMANT <u>C. Ellsworth Tanner</u> Address <u>Greenspring, Lutherville</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive C.V. Disease</u> cause last. (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 12-30</u> 19 <u>58</u> to <u>April 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Apr 3, 1961</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>M Paul Byerly</u> M.D.					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <u>M Paul Byerly</u>					22d. ADDRESS <u>3033 W 14th St A</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>April 6, 1961</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>					23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u> ADDRESS <u>3631 Falls Road</u>					25a. REC'D BY REGISTRAR <u>DATE APR 5 '61</u>									
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>														

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4073  
CERTIFICATE OF DEATH

04072

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28, Md.</b>				c. LENGTH OF STAY IN 1b <b>2 yrs 4 mos +</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 27, Maryland</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>5510 Carville Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>George</b> Last <b>Tello</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 61</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/5/96</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bottle maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penna R. R.</b>				11. BIRTHPLACE (State or foreign country) <b>Portugal</b>				12. CITIZEN OF WHAT COUNTRY? <b>Naturalized U.S.</b>			
13. FATHER'S NAME <b>George Tello</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W.L 717-07-6981</b>				17. INFORMANT <b>RECORDS: SPRING GROVE STATE HOSPITAL</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac failure due to arteriosclerotic cardiovascular disease.</b> DUE TO (c) <b></b>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>March 27</b> 19 <b>60</b> to <b>April 20</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>April 20</b> 19 <b>61</b> , and that death occurred at <b>9 p.</b> M. from the causes and on the date stated above.															
22a. SIGNATURE <b>Stella Wachler</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>April 21, 1961</b>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachler M.D.</b>				22d. ADDRESS <b>Spring Grove State Hospital Catonsville 28, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>4/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery, Borsy, Maryland</b>				23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Amber, Inc. 1328 Sulphur Spring Rd.</b>				ADDRESS <b></b>				25a. REC'D BY REGISTRAR <b>DATE APR 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>					

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UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH  
CERTIFICATE OF DEATH

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(1)

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3020 East Ave.</u>				d. STREET ADDRESS <u>3020 East Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth M. Tewey</u>				4. DATE OF DEATH <u>April 8 19 61</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-26-1868</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Gerhardt Leubehusen</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Prenger</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>same</u>		16. SOCIAL SECURITY NO. <u>same</u>		17. INFORMANT <u>Mrs Jane Sipes</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>422.1</u> (e), stating the underlying cause last. DUE TO (c) <u>422.1</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <u>May 1960</u> to <u>Apr. 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> , 19 <u>61</u> , and that death occurred at <u>11:00 Pm</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Leonard J. Ruck</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/10/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Leonard J. Ruck</u>	
22d. ADDRESS <u>7101 Harford Rd.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-11-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
23d. LOCATION (City, town or county) <u>Baltimore</u>		23e. (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24. ADDRESS <u>5305 Harford Rd.</u>	
25a. REC'D BY REGISTRAR <u>APR 11 61</u>		25b. REGISTRAR'S SIGNATURE <u>Robert L. Flannery</u>		25c. DATE <u>APR 11 61</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
4080									
04074									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>16yr11mth11dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg, Maryland</u>			d. STREET ADDRESS <u>Route #2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Thompson</u>					4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>19 61</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1887</u>		9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Andrew King</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Thompson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Clarksville, Md</u>		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 4, 19 61</u> to <u>April 7, 19 61</u> , that (I) (we) last saw the deceased alive on <u>April 7, 19 61</u> , and that death occurred at <u>2:10 p.m.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Stella Wachslar</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4-7-61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>					22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-10-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Linthicum Chapel</u>			23d. LOCATION (City, town or county) (State) <u>Clarksville, Md</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>F.C.Higinbotham, Ellicott City, Md</u>					25a. REC'D BY REGISTRAR DATE <u>APR 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		

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E.C. 11/11/11

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAY 1961

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10-10-80 BY 60322 UCBAW/STP

Charles R. Law 202 Madison Ave., Suite 1100

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April 27, 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4082

## CERTIFICATE OF DEATH

Reg. Dist. No.

04076

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>60 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6700 Brighton Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DR. HARRY</b> First <b>ALVIN</b> Middle <b>UHLER</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1874</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>YRS.</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chiropractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Profesional</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Uhler</b>		14. MOTHER'S MAIDEN NAME <b>Annie Spurrier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Ellen C. Uhler</b>		Address <b>6700 Brighton Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DIS.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 YRS.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FALL, 1952</b> , to <b>APRIL 27, 1961</b> , that I last saw the deceased alive on <b>APRIL 27, 1961</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Marvin Goldstein</b>		ADDRESS (Street, city or town, state) <b>5334 LIBERTY HEIGHTS AVE. BALTIMORE 7, MD</b>	
PHYSICIAN'S NAME (Type) <b>MARVIN GOLDSTEIN</b>		DATE SIGNED <b>4/27/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William E. Johnson</b>		ADDRESS <b>1557 Northren Pkwy. Baltimore 12, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	



CERTIFICATE OF DEATH

DATE OF DEATH 1942		PLACE OF DEATH BALTIMORE	
DECEASED JAMES J. JONES		AGE 30 years	
SEX Male		RACE White	
MARRIAGE Married		MANNER OF DEATH Suicide	
RESIDENCE 1000 Lexington Ave.		PLACE OF BIRTH BALTIMORE	
DATE OF BIRTH April 1, 1912		EDUCATION High School	
OCCUPATION Salesman		RELIGION Catholic	
CAUSE OF DEATH Suicide		MANNER OF DEATH Suicide	
PLACE OF DEATH BALTIMORE		DATE OF DEATH 1942	
DECEASED JAMES J. JONES		AGE 30 years	
SEX Male		RACE White	
MARRIAGE Married		MANNER OF DEATH Suicide	
RESIDENCE 1000 Lexington Ave.		PLACE OF BIRTH BALTIMORE	
DATE OF BIRTH April 1, 1912		EDUCATION High School	
OCCUPATION Salesman		RELIGION Catholic	
CAUSE OF DEATH Suicide		MANNER OF DEATH Suicide	
PLACE OF DEATH BALTIMORE		DATE OF DEATH 1942	
DECEASED JAMES J. JONES		AGE 30 years	
SEX Male		RACE White	
MARRIAGE Married		MANNER OF DEATH Suicide	
RESIDENCE 1000 Lexington Ave.		PLACE OF BIRTH BALTIMORE	
DATE OF BIRTH April 1, 1912		EDUCATION High School	
OCCUPATION Salesman		RELIGION Catholic	
CAUSE OF DEATH Suicide		MANNER OF DEATH Suicide	
PLACE OF DEATH BALTIMORE		DATE OF DEATH 1942	

1942



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4083

04077

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville (28)</b>		c. LENGTH OF STAY IN lb <b>205 W Madison St</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Caton Ridge Nursing Home, 329 Harlem La.</b>		d. STREET ADDRESS <b>Shirley Hotel</b>	
3. NAME OF DECEASED (Type or print) <b>Nellie Wagner</b>		4. DATE OF DEATH Month Day Year <b>April 9, 1961 19</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/31/1886</b>
9. AGE (In years last birthday) <b>74rs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Clark</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sheldon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-18-3993</b>	
17. INFORMANT <b>Mrs. Elsie Kirby, 4606 Maine Av., Balto. 7, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.1</b> DUE TO <b>Toxemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio-sclerotic Gangrene RT leg</b> DUE TO (c) <b>Age</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> , 19 <b>60</b> to <b>4/9</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2/3</b> , 19 <b>61</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Cliff Ratliff</b>		22b. DATE SIGNED <b>4/11/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b>		22d. ADDRESS <b>4605 Edmondson Blvd 29</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/12/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore County</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 12 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		DATE	

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(2) *Latent*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04078

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8100 Old Phila. Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8100 Old Phila. Road</u>		d. STREET ADDRESS <u>8100 Old Phila. Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Walter</u> Last <u>Walter</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Can Company</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Jacob Walter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Haertlein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-4667</u>	17. INFORMANT <u>Mr John Walter</u> Address <u>8100 Old Phila. Road</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular disease</u> DUE TO <u>2 yrs</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>61</u> , to <u>4/7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/7</u> , 19 <u>61</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Balds 6 Md</u>		DATE SIGNED <u>4/7/61</u>	
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-11-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Stenners Rd Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loach Funeral Home</u> ADDRESS <u>7701 Belair Road</u>		24a. REC'D BY REGISTRAR <u>APR 10 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4085

04079

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>44 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>✓</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>214 E. Federal Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>FRED B. WATSON</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>29</u> Year <u>19 61</u>		<b>5. SEX</b> <u>Male</u>							
<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>January 16, 1896</u>							
<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Orderly</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Jones County, North Carolina</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Madison Watson</u>									
<b>14. MOTHER'S MAIDEN NAME</b> <u>Janie Cooper</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>WW-1</u>									
<b>17. INFORMATION</b> <u>Clinical Records, 3900 Loch Raven Blvd. Baltimore 18, Md. FORT HOWARD DIVISION</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> (b) <u>GASTRIC HEMORRHAGE</u> (c) <u>POLYCYSTIC KIDNEY DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u> <u>40 Years</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 16, 1961</u> , to <u>April 29, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 29, 1961</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Norman P. Jones</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>NORMAN P. JONES, M.D.</u>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22d. ADDRESS</b> <u>VAH 3900 Loch Raven Blvd. Baltimore 18, Md. Fort Howard Division</u>							
<b>22b. DATE SIGNED</b> <u>4/29/61</u>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>									
<b>23b. DATE THEREOF</b> <u>5-3-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery</u>									
<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Randolph J. Collick</u>									
<b>25a. REC'D BY REGISTRAR</b> <u>MAY 8 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04080

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28, Md.		c. LENGTH OF STAY IN 1b 3yrs 10 mos +	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daisy Middle S. Last Ways		4. DATE OF DEATH Month April Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/80
9. AGE (In years lost birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None House wife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Deceased Henry Umbach	
14. MOTHER'S MAIDEN NAME Deceased Catherine Spealmonn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized, severe (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 20, 1961, to April 20, 1961, that (I) (we) last saw the deceased alive on April 20, 1961, and that death occurred at p. M., from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED April 21, 1961	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar		22d. ADDRESS Spring Grove State Hospital Catonsville 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/1961	
23c. NAME OF CEMETERY OR CREMATORY Mtountain View Cemetery		23d. LOCATION (City, town, or county) (State) Howard Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home - Catonsville, Md.		25a. REC'D BY REGISTRAR DATE APR 25 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Knead			

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CERTIFICATE OF DEATH

1900

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(1)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital, attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4087  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04081

1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year		5. SEX 6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday) yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 11-30-1961 to 4-19-1961, that (I) (we) last saw the deceased alive on 4-19-1961, and that death occurred at 7:30 AM, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	

Burial 4-22-61 Dulaney Valley Memorial Cockeysville Md.

Brooks Funeral Service Towson 4, Md. DATE APR 24 '61 Arthur S. House

10000

CERTIFICATE OF DEATH

1911

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1

THE HOSPITAL

Brooks Funeral Service  
11-12-11  
Burial 11-12-11  
Cook County, Illinois

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

(M)

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MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2800 Roslyn Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ROGER</b>			First Middle Last <b>--- WEBB</b>		4. DATE OF DEATH <b>April 6 1961</b>		Month Day Year		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>12/5/15</b>		9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Harrisburg, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Henry Webb</b>					14. MOTHER'S MAIDEN NAME <b>Mildred Johnson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>WW II 183-12-1813</b>		17. INFORMANT <b>Clin. Rec. VAH, Balto. Md. Ft. Howard Div.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>978X FRACTURED CERVICAL SPINE</b> DUE TO (b) <b>PROBABLE FRACTURE OF SKULL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>PARANOIA PSYCHOSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PARANOIA PSYCHOSIS</b>										INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Jumped from third story window VAH, Balto. Md. Ft. Howard Division</b>							
20c. TIME OF INJURY <b>1:05 p.m. 4/6/ 1961</b>			20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, FT. HOWARD, MD.</b>		20f. (City or town) <b>FORT HOWARD, BALTO.</b>		(County) <b>19 MD.</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Melvin B. Davis M.D.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M.D.</b>					DATE SIGNED <b>4/6/61</b>					
Address (Street, city, town, or county)										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			22b. DATE THEREOF <b>4-9-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>		22d. LOCATION (City, town, or country) <b>Steelton, Pennsylvania</b>			(State)
23. FUNERAL DIRECTOR <b>Arlington S. Phillips Funeral Home,</b>					ADDRESS <b>Balto 17, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

100-443888-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4089 CERTIFICATE OF DEATH 04083											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1717 Kurtz Ave.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> d. STREET ADDRESS <u>1717 Kurtz Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Ida Watts Weisbrod</u>			4. DATE OF DEATH <u>April 1, 1961</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Sept. 19, 1882</u>			9. AGE (In years last birthday) <u>78</u> yrs.			IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Lucien Watts</u>					
14. MOTHER'S MAIDEN NAME <u>Jennie Burnley</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)					
16. SOCIAL SECURITY NO. <u>—</u>						17. INFORMANT <u>Family Records</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>1 MIN.</u> <u>5 YRS.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>APRIL 1957</u> to <u>APRIL 1, 1961</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>MARCH 1961</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>William A. Pillsbury</u> M.D.											
22b. DATE SIGNED <u>4-3-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>											
22d. ADDRESS <u>2060 YORK RD TIMONIUM MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
23b. DATE THEREOF <u>Apr. 3, 1961</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>											
23d. LOCATION (City, town or county) (State) <u>Towson, Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Md.</u> ADDRESS											
25a. REC'D BY REGISTRAR <u>DATE APR 10 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3090

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

04084

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY in 1b <b>18 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>22 New Jersey Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WALTER</b> Middle <b>D.</b> Last <b>WENERSKI</b>				<b>4. DATE OF DEATH</b> Month <b>APRIL</b> Day <b>7</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5/4/96</b>	
<b>9. AGE</b> (In years last birthday) <b>64</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>2</b>		<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>2</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Rigger</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bethlehem Steel Co.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>							
<b>13. FATHER'S NAME</b> <b>Michael Wenerski</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Theodora KOLANKIEWICZ</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>215-05-7360</b>			
<b>17. INFORMANT</b> <b>Clin. Rec. VAH, Balto. Md. Fort Howard Division</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)			
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>MYOCARDIAL INFARCTION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <b>(b)</b> <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>(c)</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5-6 Hours</b> <b>UNKNOWN</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>PARAPLEGIA</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> (this hospital) <b>attended the deceased from March 20, 1961, to April 7, 1961, that (y) (we) last saw the deceased alive on April 7, 1961, and that death occurred at 11:25 PM, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Lawrence D Marcus</b> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>4/8/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>VAH, Balto. Md. Fort Howard Division</b>				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>4/11/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Green Haven Moreland Memorial Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Glen Burnie, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Fiakowski Funeral Home</b>				<b>25a. REC'D BY REGISTRAR</b> <b>4200 Pennsylvania Ave. Curtis Bay, Maryland</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>APR 10 '61</b> <b>Arthur S. Kraus</b>	

VR A15 (4)  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4091

## CERTIFICATE OF DEATH

Reg. Dist. No.

04085

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>1 Yr.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Fishkill</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor for Aged &amp; Convalescents</b>		d. STREET ADDRESS <b>Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Theophilus Wells</b>		First Middle Last <b>escenta Wells</b>		4. DATE OF DEATH Month Day Year <b>April 18, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1877</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Methodist Conf.</b>		11. BIRTHPLACE (State or foreign country) <b>Newfoundland (St. John's)</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Nathaniel Wells</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Albert E. Wells 828 Braeside Ave. (29)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial insufficiency</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio sclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 12, 1960</b> , to <b>April 18, 1961</b> , that I last saw the deceased alive on <b>April 18, 1961</b> , and that death occurred at <b>8:30 p. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>George A. Knipp</b>		M.D. <b>1116 Edmonson Ave. Balto., 29 Md</b>		DATE SIGNED <b>Apr. 19 1961</b>	
PHYSICIAN'S NAME (Type) <b>George A. Knipp M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4-19-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>	
22d. LOCATION (City, town, or county) (State) <b>Massena, New York</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		ADDRESS <b>3207 W. North Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 21 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4092

04086

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Waterfoot Farm</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u> d. STREET ADDRESS <u>Waterfoot Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Marion G. Wessel</u>		4. DATE OF DEATH <u>April 25, 1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1902</u>		9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William E. George</u>				14. MOTHER'S MAIDEN NAME <u>Lillie G. ?</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Mr. Louis C. Wessel-Waterfoot Farm, Butler, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebral Arterio Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Old Cerebral Thrombosis (6 weeks duration)</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>61</u> , to <u>4/25/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/24/1961</u> , and that death occurred at <u>3:40 p.m.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>M. C. Porterfield</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>M. C. Porterfield</u>				22d. ADDRESS <u>Hampstead, Md.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4-28-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>				23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State)									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tackner &amp; Sons</u>				ADDRESS <u>Baltimore 17, Md</u>				25a. REC'D BY REGISTRAR DATE <u>APR 26 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Wm J. Tackner</u>							

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(M)

(I)

*Handwritten signature*  
M. J. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
4093 04087											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTO</b>						c. LENGTH OF STAY IN 1b <b>13 yrs.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>145 1/2 POPLAR RD.</b>						d. STREET ADDRESS <b>ROUTE 13, BALTO. LI</b>					
3. NAME OF DECEASED First <b>IDA</b> Middle <b>MAE</b> Last <b>WEST</b>						4. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>1961</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-4-1887</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>STEPHEN HARTER QUEEN</b>						14. MOTHER'S MAIDEN NAME <b>LOUISA ROBERTS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>JAMES WEST (HUSBAND) ABOVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerotic Cardio Vascular disease</b> (c) <b>10 yrs</b> DUE TO (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1961</b> to <b>April 18, 1961</b> that (I) (we) last saw the deceased alive on <b>April 17, 1961</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John G. Connelly</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/19/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>John G. Connelly</b>						22d. ADDRESS <b>Balto 6 Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>			23b. DATE THEREOF <b>4-19-61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>SPENCER CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>SPENCER, WEST VIRGINIA</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly</b> Exec - Md.						25a. REC'D BY REGISTRAR DATE <b>APR 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4094

Items 8 & 9 Film Q284 4/11/61 iwk

04088

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Rockdale</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Rockdale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3304 Rolling Rd. Balto. 7</b>				d. STREET ADDRESS <b>3304 Rolling Rd. Balto. 7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. Ruben</b>		First <b>Edward</b>		Last <b>Whitcomb</b>		4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1884</b> <b>Nov. 16, 1907</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Well Digger Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Well Digging</b>		11. BIRTHPLACE (State or foreign country) <b>Glyndon, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Whitcomb</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Fuller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-8443</b>		17. INFORMANT <b>Mrs. Annie A. Horne, 3304 Rolling Rd. Balto. 7, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pneumonia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asphyxiated C.V. Renal disease</b> DUE TO (c) <b>10 Years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 15, 1956</b> to <b>4/13, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>4/12, 1961</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Edwin Pierpont</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edwin Pierpont</b>				22d. ADDRESS <b>8204 Liberty Rd. Baltimore 7, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>				8728 RESS: Liberty Rd. Randallstown, Md.		25a. REC'D BY REGISTRAR DATE <b>APR 7 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

CERTIFICATE OF DEATH

MADE BY THE STATE OF CALIFORNIA

1912

State of California, County of \_\_\_\_\_  
I, \_\_\_\_\_, Registrar of the County of \_\_\_\_\_, do hereby certify that \_\_\_\_\_  
born \_\_\_\_\_ at \_\_\_\_\_, \_\_\_\_\_, California, died \_\_\_\_\_ at \_\_\_\_\_, \_\_\_\_\_, California,  
of \_\_\_\_\_, at the age of \_\_\_\_\_ years, \_\_\_\_\_ months, and \_\_\_\_\_ days.  
The death was caused by \_\_\_\_\_  
The death occurred at \_\_\_\_\_  
The body was buried at \_\_\_\_\_  
Witness my hand and the seal of said County at \_\_\_\_\_, California, this \_\_\_\_\_ day of \_\_\_\_\_, 1912.

CERTIFICATE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this Certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

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4095  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04089

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>1209 Linden Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>Charles</b> Last <b>White</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1961</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 30, 1926</b>	9. AGE (In years last birthday) <b>34</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown Stanley White</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Marie Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Army PFC 1952-55</b>		16. SOCIAL SECURITY NO. <b>212-220-546</b>		17. INFORMANT <b>Mrs. Dorothy S. Snair-1825 Palmer Avenue</b> Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4-20-61</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>MODERATE ARTERIAL HYPERTENSION - ALCOHOLISM</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>—</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 30</b> <b>1961</b> to <b>April 16</b> <b>1961</b> that (I) (we) last saw the deceased alive on <b>April 15</b> <b>1961</b> , and that death occurred at <b>7:45</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Aristides Simopoulos</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-17-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aristides Simopoulos, M. D.</b>				22d. ADDRESS <b>—</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-20-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. ...</b>				25a. REC'D BY REGISTRAR <b>APR 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

0-1000

CERTIFICATE OF DEATH

1000-00

(M)

(1)



TO TOHOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

4086

04090

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4yrlmth25dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>336 East 25th Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Juanita</b> Middle <b>Whittle</b> Last <b>—</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1872</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife —</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Whittle</b>		14. MOTHER'S MAIDEN NAME <b>Bardelia O'Brien</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15 9:00</b> to <b>April 10 1961</b> , that (I) (we) last saw the deceased alive on <b>April 10 1961</b> , and that death occurred at <b>a. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>4-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-13-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cmo.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto, Ind.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Forley - Granady &amp; FH - Catonsville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. Hanna</b>			

CONFIDENTIAL

24

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)  
ISM 9/59

4097

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04091

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>83X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>5Yrs. 6Mos. 29DAs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>THE SHEPPARD AND ENOCH PRATT HOSPITAL</u>		d. STREET ADDRESS <u>720 S. Lee Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Frederick Mark Wickham</u>		4. DATE OF DEATH Month Day Year <u>April 27 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 7, 1879</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Utilities</u>	
11. BIRTHPLACE (State or foreign country) <u>Quebec, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Martin Wickham</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anne Swift</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Brain Synd. due to Central arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 yrs +</u> <u>"</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28, 1955</u> to <u>April 27, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 26, 1961</u> , and that death occurred at <u>1:58 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. W. Elgin</u>		22b. DATE SIGNED <u>April 27, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. W. Elgin, M.D.</u>		22d. ADDRESS <u>Towson 4, Maryland</u> <u>The Sheppard and Enoch Pratt Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-29-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. &amp; Son Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 1 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

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MADE IN



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 1 & 2 Film G285

4/18/61 iwk

04092

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>Sparrows Point</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland, Baltimore</b>		b. COUNTY <b>Maryland, Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		d. STREET ADDRESS <b>7404 Bay Front Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Andrew L. Williams</b>		First		Middle		Last		4. DATE OF DEATH <b>April 7, 1961</b>		Month		Day		Year			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/3/87</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania R.R.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>David Williams</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Wood</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>716-10-6115</b>		17. INFORMANT <b>Mrs. Louise L. Williams, 7405 Bay Front Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE WITH METASTASES</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b> 20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)												INTERVAL BETWEEN ONSET AND DEATH <b>8-12 mos.</b>					
21. I certify that (I) (this hospital) attended the deceased from <b>4/17, 1961</b> to <b>4/17, 1961</b> , that (I) (we) last saw the deceased alive on <b>4/17, 1961</b> , and that death occurred at <b>4:35 P.M.</b> from the causes and on the date stated above.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
22a. SIGNATURE <b>Barnett Berman</b>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/11/61</b>		22c. PHYSICIAN'S NAME (Type) <b>BARNETT BERMAN, MD</b>		22d. ADDRESS <b>714 PARK AVE., BALTO-1</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		23d. LOCATION (City, town or county) <b>Anne Arundel Co.</b>		23e. REC'D BY REGISTRAR <b>APR 13 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>		24. ADDRESS <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

4093

04093

M

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>1521 Lemon St. Balto 23, Md.</b>		
3. NAME OF DECEASED (Type or print) <b>CHARLES E. WILLIAMS</b>			4. DATE OF DEATH <b>April 8 1961</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>December 7, 1897</b>		9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Laurel, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Williams</b>			14. MOTHER'S MAIDEN NAME <b>Eliza Williams</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW-1</b>			16. SOCIAL SECURITY NO. <b>218-10-5191</b>		
17. INFORMANT <b>Clinical Records, 3900 Loch Raven Blvd. Baltimore 18, Md.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE PULMONARY INFARCTIONS</b> DUE TO <b>465X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>EMBOLI FROM LEFT ATRIAL THROMBUS with ARTERIOSCLEROTIC HEART DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary Emphysema</b>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3900</b>			20f. (City or town) (County) (State) <b>Baltimore</b>		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 5, 1961</b> to <b>April 8, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 8, 1961</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Lawrence D. Marcus</b> M.D.			22b. DATE SIGNED <b>APR 12 '61</b>		
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE D. MARCUS, M.D.</b>			22d. ADDRESS <b>VAH 1800 Loch Raven Blvd. Baltimore 18, Md. Fort Howard Division</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4-12-61</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>			25a. REC'D BY REGISTRAR <b>APR 12 '61</b>		
25b. REGISTRAR'S SIGNATURE <b>C. S. Kline</b>					

506

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

04094

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>605 S. Pulaski Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELMER R. WILLIAMS</b>		4. DATE OF DEATH <b>April 6 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 8, 1894</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>16</b>	IF UNDER 24 HRS. Hours <b>16</b> Min. <b>45</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles E. Williams</b>	
14. MOTHER'S MAIDEN NAME <b>Mollie Childs</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>705-09-1589</b>		17. INFORMANT <b>Clin. Records, VAH, Balto. Md. Ft. Howard Div.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE STOMACH</b> DUE TO (b) <b>CARCINOMATOSIS</b> DUE TO (c) <b>CAUSE OF DEATH</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 21, 1961</b> to <b>April 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1961</b> , and that death occurred at <b>4:55 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Crahan</b> M.D.		22b. DATE SIGNED <b>4/6/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M. D.</b>		22d. ADDRESS <b>VAH, BALTO. MD. FT HOWARD DIVISION</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. ADDRESS (City, town, or County) (State) <b>5600 Dogwood Rd. Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas N. Miller</b> ADDRESS <b>Schwab Funeral Home, 2101 Frederick Ave. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>APR 10 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

VR A15 (4)  
15M 9/60

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(I)

Belmont

Belmont

Belmont

to leave

to leave

Box 2, Belmont Street

Belmont Administration Hospital

Belmont

Belmont

January 2, 1954

Belmont

Belmont

U.S.A.

Belmont, Virginia

Belmont

Belmont

Belmont

Belmont

Box 2, Belmont Street, Belmont, Virginia

Belmont

Belmont

April 2

April 2

April 2

Belmont, Virginia

Belmont, Virginia

Belmont, Virginia

Belmont, Virginia

Belmont

Belmont, Virginia

Belmont, Virginia



Carlton L. Frank

VR A15 (4)  
15M 9/60

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FOR THE RECORD

21 days

RECEIVED

Veterans Administration Hospital

U.S. Veterans Hospital

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U.S. Army

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U.S. Army, North Carolina

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital, and the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

4-7-61

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04096											
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN, 1b <b>3 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b> d. STREET ADDRESS <b>Box 529 1 Tupelo Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>DORIS</b> First <b>ESTELLE</b> Middle <b>WILSON</b> Last 4. DATE OF DEATH <b>4</b> Month <b>4</b> Day <b>1961</b> Year											
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2.14.1926</b>		9. AGE (In years last birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>				11. BIRTHPLACE (State or foreign country) <b>Elm City, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH T. COBB</b>						14. MOTHER'S MAIDEN NAME <b>ADDIE MAE LANDING</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO (b) <b>13 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1.26.1961</b> to <b>4.4.1961</b> , that (I) (we) last saw the deceased alive on <b>4.4.1961</b> , and that death occurred at <b>1 p.m.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>W. Newcomer</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>W. Newcomer, M.D., Superintendent</b>						22b. DATE SIGNED <b>4.4.1961</b> 22d. ADDRESS <b>Mt. Wilson State Hospital, Mt. Wilson, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>April 7, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Church Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fountain Green, Harf. Co., Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Foster</b> ADDRESS <b>W. Broadway &amp; Williams Street BEL Air, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>APR 6 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

11200

CERTIFICATE OF DEATH

NO.

DORIS

F W

Home

Joseph T. Carr

40

2-18-32

2000 N. C.

ADIE MRS. LANDIN

Home

For information of the family

11200

X

For information of the family

For information of the family

For information of the family

For information of the family

For information of the family

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

1  
FOR STATE  
HEALTH DEPT.

M

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MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
4103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
04097										
1. PLACE OF DEATH a. COUNTY BALTIMORE					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6803 York Road					d. STREET ADDRESS 1339 W. North Ave -7					
3. NAME OF DECEASED (Type or print) First Middle Last FRANK MORAN WILSON					4. DATE OF DEATH Month Day Year April 28, 1961					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1916		9. AGE (in years last birthday) 45 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Littleton, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13. FATHER'S NAME Joshua Wilson					14. MOTHER'S MAIDEN NAME Hattie Vinson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II					16. SOCIAL SECURITY NO. 216-01-7896		17. INFORMANT Louise Wilson - 1339 W. North Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction										
DUE TO (b) arteriosclerotic cardiovascular disease.										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William V. Lovitt, Jr., M. D.					M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 29, 1961					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF May 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR Charles R. Law					ADDRESS 802 Madison Ave., Balto., Md		24a. REC'D BY REGISTRAR DATE MAY 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

Item 18 Film 286 5-4-61 ans									
MAYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
4104 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04098									
1. PLACE OF DEATH e. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1211 Greystone Rd.</b>					d. STREET ADDRESS <b>1211 Greystone Rd.</b>				
3. NAME OF DECEASED (Type or print) <b>MARY</b>					4. DATE OF DEATH <b>April 24, 1961</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 11, 1908</b>		9. AGE (In years last birthday) <b>52</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saleslady</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery-Wards</b>			11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>									
13. FATHER'S NAME <b>James W. Keatts</b>					14. MOTHER'S MAIDEN NAME <b>Inez Shelton</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>215-01-1070</b>				
17. INFORMANT <b>Wm. J. Wilson</b>					Address <b>1211 Greystone Rd. #27</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE <b>Peter W. Rieckert</b> EXAMINER'S NAME (Type) <b>Peter W. Rieckert, M.D.</b> M.D. <b>Medical Investigator</b> DATE SIGNED <b>4/24/61</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/27/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or country) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard</b>					24a. REC'D BY REGISTRAR DATE <b>APR 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		



# 1 4105 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04099

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X White Marsh</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1896 Carrington Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>WUNDER</u> Last <u>WUNDER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-90</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver - Balto. City</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Ind.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-01-3131</u>			
17. INFORMANT <u>Wife (same as above)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LIREMIA</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC GLOMERULAR NEPHRITIS 24yrs.</u> DUE TO (c) <u>Hypertensive Cardiovas. Dis.</u> 10yrs				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>61</u> , to <u>4/24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>61</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford F. Hudson, M.D.</u>				ADDRESS (Street, city or town, state) <u>FORK, MD.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly</u>				ADDRESS <u>418 Eastern Blvd.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 61</u>	
24b. REGISTRAR'S SIGNATURE <u>Christine S. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-10-1911

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1866		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIED		YES		YES		YES		YES		YES		YES		YES		YES	
OCCUPATION		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
DATE OF DEATH		10-10-1911		10-10-1911		10-10-1911		10-10-1911		10-10-1911		10-10-1911		10-10-1911		10-10-1911	
PLACE OF DEATH		HOME		HOME		HOME		HOME		HOME		HOME		HOME		HOME	
SIGNATURE OF PHYSICIAN		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
SIGNATURE OF REGISTRAR		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

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10-10-1911

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**4106 CERTIFICATE OF DEATH**

Reg. Dist. No. **04100**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
c. LENGTH OF STAY IN 1b <u>16 yrs.</u>		d. STREET ADDRESS <u>1 Walker Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walker Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>R.</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Manufacturer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph W. Young</u>		14. MOTHER'S MAIDEN NAME <u>Amanda V. Rodgers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>162-323822</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec.</u> 19 <u>55</u> , to <u>APRIL 27, 1961</u> , that I last saw the deceased alive on <u>APRIL 17</u> 19 <u>61</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Robinson</u>		ADDRESS (Street, city or town, State) <u>New Freedom, Pa.</u> DATE SIGNED <u>5-1-61</u>	
PHYSICIAN'S NAME (Type) <u>R. ROBINSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-2-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>	22d. LOCATION (City, town, or county) <u>Parkton, Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 2 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>

Page 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TABLE 1. *Estimated and observed values of the parameters of the model for the 1997-1998 season*



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4107  
CERTIFICATE OF DEATH

04101

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stansbury Mill Rd.</b>		d. STREET ADDRESS <b>Stansbury Mill Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>May</b> Last <b>Zinkhan</b>		4. DATE OF DEATH Month <b>4-</b> Day <b>8-</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-18-1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nurse</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Troyer</b>		14. MOTHER'S MAIDEN NAME <b>Annie Melvin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-20-5578</b>	
17. INFORMANT <b>Mrs. Shelben Thompson Phoenix, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Intestines</b> 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 20, 1960</b> to <b>March 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 31, 1961</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Theodore G. de Cueva</b>		22b. DATE SIGNED <b>April 10, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Theodore G. de Cueva</b>		22d. ADDRESS <b>Cockeysville - Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Jacksonville Reform</b>		23d. LOCATION (City, town, or county) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service Towson 4, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 17 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

